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ABSTRACT

Part of a series designed to provide guidance for communities interested in building systems of care for children with emotional disturbances, this volume addresses mental health services for very young children and their families. A literature review was conducted, and four Community Mental Health Services for Children and Their Families Program sites and one community-based early childhood mental health service delivery site were visited. In nearly all cases, the promising practices increased child and family satisfaction with services: (1) supports and services are designed according to the family's strengths, needs, and preferences; (2) programs and services respect families' racial, cultural, and socioeconomic backgrounds; (3) service arrays include a variety of interventions that take account of the developmental, health, and mental health needs of families; (4) community-based interventions are provided in natural environments; (5) coordinated services are provided; (6) family members are active participants

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at all levels of decision making; (7) effective programs address the developmental needs of children in all areas of functioning; (8) interventions are designed to promote resilience in children and build on family strengths by enhancing self-esteem, improving coping strategies, and increasing positive social support. Appendices include examples of promising practices. (Contains approximately 100 references.) (CR)

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Comprehensive Community Mental Health Services for Children and Their Families Program

Systems of Care
Promising Practices in Children's Mental Health
2001 Series

ED 470 530

VOLUME III

PROMISING PRACTICES IN EARLY CHILDHOOD MENTAL HEALTH

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Division of Knowledge Development and Systems Change
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Substance Abuse and Mental Health Services Administration
U.S. Department of Health and Human Services

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FOREWORD

It is with great pleasure that we present the third collection of monographs of the *Systems of Care: Promising Practices in Children's Mental Health* of the Comprehensive Community Mental Health Services for Children and Their Families Program. The 2001 Series connotes a time of new beginnings for this seven-year-old federal grant program, which assists communities in building fully inclusive, organized systems of care for children who are experiencing a serious emotional disturbance and their families. It also represents a year of validation and pride for those who have been involved with this movement for years. As more and more evidence on the effectiveness of the system of care approach amasses, we have been able to gain increased support to expand the number of grant communities and the investigation of promising practices within those communities. Owing to the proven success of the Comprehensive Community Mental Health Services for Children and Their Families Program, this year's budget reauthorization afforded our grant communities an extension of their grants, thereby expanding their community-based initiatives from five-year to six-year programs.

In his millennium report on mental health, Surgeon General David Satcher stated, "Across the Nation, certain mental health services are in consistently short supply. These include the following: wrap-around services for children with serious emotional problems and multisystemic treatment. Both treatment strategies should actively involve the participation of the multiple health, social service, educational, and other community resources that play a role in ensuring the health and well-being of children and their families." Our grant communities employ these effective approaches in combination with other community-based strategies to help these children and their families thrive. As those of us fortunate enough to participate in this initiative grow and learn, we maintain a commitment to share our knowledge and resources with all communities.

Until recently, throughout this nation, and especially in Native American communities, most children living with a serious emotional disturbance have not received clinically, socially, or culturally appropriate care. These young people have been systematically denied the opportunity to share in the home, community, and educational life that their peers often take for granted. Instead, these children live lives fraught with separation from family and community, being placed in residential treatment centers or in-patient psychiatric centers hundreds and even thousands of miles away from their home. For many of these young people, families, and communities, the absence of certain types of information has fueled the continued existence of inadequate and unresponsive service delivery systems. Staff at these service delivery networks often believe that they have no alternative but to separate these children from their families and place them in costly, long-term, out-of-home placement. The *Promising Practices* Initiative is one small step to ensure that all Americans can have the latest available information about how best to help serve and support children who live with serious mental health problems at home and in their community.

Systems of Care: Promising Practices in Children's Mental Health is an annual publication that features the strengths of the systems of care being developed in this country through the support of the Comprehensive Community Mental Health Services for Children and Their Families Program. The grant program has helped develop cutting-edge technologies for forming effective systems of care throughout this country. The *Promising Practices* monograph series is a way for us to inform the thousands of communities that do not have the benefit of participation in the grant program about the emerging approaches and innovations occurring in systems of care. The *Promising Practices* series provides guidance for communities and caregivers interested in building exemplary systems of care and gives system builders the latest available information about how best to help serve and support children who live with serious emotional disturbances at home and in their communities. The monographs show that the Comprehensive Community Mental Health Services for Children and Their Families Program has evaluated and developed promising practices that represent an invaluable return on the nation's investment. Used in the grant communities, the *Promising Practices* series has clearly enhanced, and will continue to directly improve, the health and lives of children and families throughout the country.

Emerging systems of care within communities will certainly benefit the national knowledge base on how best to support the mental health needs of children who present major challenges, especially the contributions made by the grant communities themselves. We are proud that the information contained in these monographs has been garnered within the grant communities of the Comprehensive Community Mental Health Services for Children and Their Families Program. The information was gathered by visiting sites, holding focus groups, collecting data by the national program evaluation involving all grantees, and interviewing numerous professionals and parents.

The 2001 *Promising Practices* series includes the following volumes:

- *Volume I—Wraparound: Stories From the Field* explores the ever-burgeoning conviction in a growing community of providers, advocates, and families that Wraparound is simply better, cheaper, and more humane than conventional service delivery processes for families with children with serious emotional disturbance. Through the stories of six families who have received individualized services and supports through a Wraparound process, we see how this process worked to support their strengths and meet their needs.
- *Volume II—Learning From Families: Identifying Service Strategies for Success* examines the success stories of families with children who suffer from emotional and behavioral disorders. Family success, defined from the perspectives of the families and providers, occurs when systems of care focus on the entire family, meet families "where they are," and emphasize the connection between family and community. The monograph emphasizes the crucial importance of strong bonds between families and providers.
- *Volume III—Promising Practices in Early Childhood Mental Health* shows us that systems of care serving very young children and their families are finding innovative and effective ways to design and deliver services. The authors consistently found that an approach to services that takes into account the whole child, including his or her family and community, his or her unique developmental needs and strengths, and his or her well-being in a variety of contexts is especially important and most effective. They also found that a truly family-centered approach to care with a high level of parent participation in decision making seems to increase the overall level of parent engagement in the well-being of their child within a particular child-serving agency.

As you read through each volume, you may have a sense that some topics you would like to read about are not to be found in this series. We would expect that to happen simply because so many issues need to be addressed. We fully expect this series of documents to become part of the culture of this critical program. If a specific topic is not here today, look for it tomorrow. In fact, let us know your thoughts on what would be most helpful to you as you go about ensuring that all children have a chance to have their mental health needs met within their home and community.

The communities that have been fortunate enough to participate in our federally funded initiative have been able to incubate solutions and promising practices that work! This series represents a gift of collective knowledge and lessons learned from our grant communities to those struggling to develop effective systems of care throughout the nation.

So the 2001 *Promising Practices* series is now yours to read, share, discuss, debate, analyze, and use. Our hope is that the information contained throughout this series stretches your thinking and results in your being more able to realize our collective dream that all children, no matter how difficult their disability, can be served in a quality manner within the context of their home and community. COMMUNITIES CAN!

Joseph Autry
Acting Administrator
Substance Abuse and Mental Health
Services Administration

Bernard Arons
Director
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DEDICATION

The authors dedicate this monograph to the memory of Rico Pallota, Executive Director of the Positive Education Program from 1971 until his death in 1998. His pioneering and tireless work in the field of children's mental health demonstrated his belief that services should be offered in partnership with families, schools, and communities. We are pleased to recognize his boundless passion, energy, and vision in support of children with mental, behavioral, and emotional challenges and their families.

ACKNOWLEDGMENTS

The Promising Practices 2001 series is the culmination of the efforts of many individuals and organizations that committed endless hours participating in the many interviews, meetings, phone calls, and drafting of the documents that you see represented here. Special appreciation goes to all of the people involved in the grants of the Comprehensive Community Mental Health Services for Children and Their Families Program for going beyond the call of duty to make this effort successful. This activity was not in the grant announcement when they applied! Also a big thank you to all of the writing teams that have had to meet deadline after deadline in order to put this series together in a timely fashion. Not only did they work hard but also, as you can see, their efforts yielded great results. The staff of the Child, Adolescent and Family Branch deserve a big thank you for their support of the grantees and me in keeping this effort moving forward under the crunch of so many other activities that seems to make days blend into months. Thanks to David Osher, Cecily Darden, and their staff at the Center for Effective Collaboration and Practice for overseeing the production of the third series, specifically, Eric Spears and Diedra White for word processing and graphic layout support; Holly Baker for carefully editing all the monographs during the final production phases; and Huda Aden and Sarah Leffler for assisting in editing and proofreading. Finally, a special thanks to Dr. Dorothy Webman, who had the dubious pleasure of trying to coordinate this huge effort from the onset. Dorothy was able to put a smile on a difficult challenge and rise to the occasion. Many people have commented that her commitment to the task helped them keep moving forward to a successful completion.

EXECUTIVE SUMMARY

Attention to the mental health needs of young children and their families has substantially increased in research, theory development, and intervention in recent years. Mental health services are increasingly considered necessary for very young children and their families as teachers, service providers, researchers, and advocates become more aware of mental, emotional, or behavioral challenges among children ages 0 to 5. Early childhood mental health services focus on strengthening children's relationships with caregivers and promoting age-appropriate social and emotional skills, with the goal of improving the emotional and social well-being of children ages 0 to 5 and their families.[1] Services are based on models of prevention and early intervention from the field of public health and are designed (1) to promote the emotional well-being of children who are perceived to be at risk of adverse developmental outcomes, (2) to increase the skills of parents and other caregivers to promote the well-being of children at risk, and (3) to intervene early where emerging needs have been identified.

This monograph addresses mental health services for very young children and their families. It is one of a series of monographs supported by the Center for Mental Health Services and is part of the Comprehensive Community Mental Health Services for Children and Their Families Program (also known as the Community Mental Health Services for Children and Their Families Program). To develop a picture of state-of-the-art practices in early childhood mental health services, the authors completed a literature review and visited four Community Mental Health Services for Children and Their Families Program sites and one community-based early childhood mental health service delivery site. We found a range of promising practices in each site we visited and reached a number of conclusions. Throughout the monograph, we list and present the sites in alphabetical order. We believe that early childhood mental health services support the mental health of very young children when they are family-centered, individualized, comprehensive, community-based, coordinated, built on a high level of family participation, focused on developmental needs, and built on strengths and resilience.

DEVELOPMENT OF THE MONOGRAPH

The discussion of early childhood mental health is based on our review of relevant literature and our visits to agencies serving very young children. Through the literature review and visits, the authors drew on the knowledge and expertise of administrators, directors, therapists, child development specialists, policymakers, advocates, family members, and others. Our data collection included interviews with experts in special education, mental health, and disability-related fields.

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[1] Knitzer, J. (in press). Early childhood mental health services: A policy and systems development perspective. In J. P. Shonkoff & S. J. Meisels (Eds.), *Handbook of early childhood intervention*. New York: Cambridge University Press.

All interviews were qualitative and open-ended. Our goal was to understand the competencies and skills used to maximize early childhood mental health services in the local communities from the perspectives of those interviewed. In some cases, we attended wraparound teams and other meetings. We visited the following sites:

1. Children Upstream Services Program in Vermont;
2. Community Wraparound Initiative in Lyons, Riverside, and Proviso Townships in Illinois;
3. KanFocus and Project Before in southeastern Kansas;
4. Kmihqitahasultipon Program serving the Passamaquoddy tribe in Maine; and
5. Positive Education Program in Cleveland, Ohio.

All but the Positive Education Program are part of the Community Mental Health Services for Children and Their Families Program.

In addition to discussing promising practices at each site, the monograph examines the following elements of the programs we visited:

- The philosophy and goals that are central to the design and delivery of services
- The services themselves, including what types of services and supports (formal and informal) the program offers, how families are involved in the design and delivery of services, and issues of cultural competence
- Structural and financial issues, including how services are funded and how programs are structured

The first section of this monograph is a literature review that includes overviews of research and theoretical understandings in the field of early childhood mental health and of the implementation of early childhood mental health services at the policy, program, and intervention levels. The second section describes the methods we used to gather data. The third section presents results of the site visits and interviews, and the fourth offers a discussion of our conclusions and recommendations based on the study.

SUMMARY OF FINDINGS FROM THE LITERATURE

Early childhood mental health has recently emerged as a distinct arena of service delivery, drawing on philosophy and practices that have characterized Early Intervention and other early childhood fields. A growing body of research about the critical stages of brain development in the early years of life has also been influential. Information about the increasing stress that affects very young children and their families and the impact that this stress has on healthy development supports the need to attend to the mental health challenges that very young children face. There is a growing awareness of the benefits of preventive and early intervention approaches in the early childhood field. Support is increasing for the idea that early childhood mental health services can enhance the development and well-being of children of all social classes and cultural groups.

Because very young children are served by several separate service delivery sectors, including early intervention, special education, mental health, and child welfare, there is a growing emphasis in service delivery on transdisciplinary and transagency collaboration so that child-serving agencies can best meet the needs of children and their families. Theoretical frameworks based in ecological theory have led professionals in the field of early childhood mental health to broaden their focus from the child alone to the mutual transactions among the child, the family, and the community.

This broadened attention also focuses on the relevance of the cultural and socioeconomic contexts in which families live. Growing knowledge of the effects of stress on family life and of the positive benefits of social support and coping has contributed to new ways of working with families. Over time, the emphasis in service delivery has shifted from a focus on treating the child to family-centered approaches that are aimed at strengthening positive parent-child relationships and supporting effective parenting. Interventions at the family level recognize families' needs and the stresses facing parents in several domains. Services are designed to improve social support, connect families with concrete resources, increase parents' coping skills, and enhance parent-child relationships and parenting competencies.

New approaches to assessment and intervention in early childhood mental health services focus on sources of resilience and are family-centered and individualized; they are designed to meet the unique needs, and build on the unique strengths, of families. Appreciation is growing for cultural perspectives on the kinds of supports preferred by families, which has contributed to the development of more culturally competent services. Family members are now viewed as active members of the early intervention team, with roles in planning and providing services through teaching, training, therapy, and supports.

New models of early childhood services and early childhood mental health emphasize parent-to-parent support, as well as parent-professional collaboration, parent empowerment, and enhanced competence. Parents are increasingly involved in decision making at all levels of early childhood service delivery systems, and services are designed to build on the informal supports provided in community networks. Innovative programs in early childhood mental health services are typically community-based, comprehensive, strengths-oriented, and guided by family-professional partnerships. New models of evaluation used in early childhood mental health are guided by family-defined outcomes and use qualitative and holistic measures of success related to enhanced social competencies and stronger relationships.

DISCUSSION AND CONCLUSIONS

Our research and interviews demonstrated that participants in systems of care serving very young children and their families are finding innovative and effective ways to design and deliver services. Particularly when children are young, an approach to services that takes into account the whole child, including his or her family and community and his or her well-being in a variety of contexts, is especially important. Further, a high level of parent participation in making decisions about the design and delivery of services seems to increase the overall level of parent engagement in the well-being of their child within a particular child-serving agency.

From our literature review, we identified principles relevant to effective early childhood mental health services, which the five sites applied through specific promising practices. We hope that these promising practices offer examples of concrete and relevant components of mental health services for very young children and their families. In nearly all cases, the promising practices detailed below appeared to lead to increased child and family satisfaction with services. Promising practices in early childhood mental health include services that have the following characteristics:

Family-centered. Supports and services are designed according to the family's strengths, needs, and preferences. "Family" is defined in the way the family defines it and reflects diverse and dynamic family membership and patterns. In addition, family-centered services are always connected to the degree of family participation in the design and delivery of services (see below under "Built on a high level of family participation"). In all the sites we visited, service providers pay particular attention to the strengths, needs, and culture of the family with which they are working. Programs offer both informal and formal supports to families and take specific steps to stay in touch with the challenges that families are facing.

Individualized. Programs and services respect families' racial, ethnic, cultural, and socioeconomic backgrounds and their values and beliefs. Interventions are tailored to address families' unique needs and strengths. Programs that serve families well take culture into account at all levels of service design and delivery. Thoughtful and consistent attention to culture requires appropriate culturally sensitive diagnostic, assessment, and evaluation tools for early childhood mental health services.

Comprehensive. Service arrays include a variety of interventions that take account of the developmental, health, and mental health needs of families and the potentials for preventive as well as therapeutic interventions. All parents need support to raise their children well. When providers focus on the health and well-being of the entire family, they consider services such as providing transportation and child care for siblings and supporting parents' goals to complete the Graduate Equivalency Degree or obtain employment along with services such as parenting classes or individual therapy. Supportive relationships with service providers, and particularly with other parents, can make a significant difference for parents.

Community-based. Community-based interventions are provided in the natural environments of young children and their families and incorporate informal community supports. Community-based services might mean that programs serving the mental health needs of very young children and their families build on existing services instead of creating new ones. In largely rural communities, services that are home-based are considered particularly appropriate for families.

Coordinated. Since no one agency or discipline can meet the diverse, complex, and changing needs of young children with special needs and their families, coordinated services as well as transdisciplinary and transagency team approaches are appropriate. Families may interact regularly with multiple service providers. Services from different agencies can complement one another when there is coordination among agencies and collaborative relationships between providers.

Built on a high level of family participation. Family members are active participants at all levels of decision making about their children's care and are involved in designing, implementing, and evaluating services. Family-professional partnerships and collaboration are essential components of empowerment-oriented interventions. Families of children who have received mental health services are uniquely able to offer services to other parents.

Focused on developmental needs. Effective programs address the developmental needs of children in all areas of functioning. Intervention to enhance social and cognitive development when a child is very young can make a significant difference later in life. Awareness of age-appropriate behavior, alongside attention to the particular needs and strengths of the child, can help service providers offer appropriate supports and services to the child and the family.

Built on strengths and resilience. Interventions are designed to promote resilience in children and to build on family strengths by enhancing self-esteem, improving coping strategies, and increasing positive social support. We found that when services are designed to improve the well-being of the entire family and the emotional and behavioral health of the child in all the settings in which he or she interacts, outcomes (child, family, and staff) are more likely to be perceived as positive. Families are more engaged in services when they feel supported and respected in their role as parents.

Although we drew these principles for early childhood mental health from the literature and we identified examples of their implementation in the communities we visited, a coordinated or systematic early childhood mental health response does not exist across the country. Without an entity responsible for meeting the mental health needs of young children and their families, services are fragmented and haphazard. Families who are challenged by poverty, substance abuse, or mental illness are at a particular disadvantage. Some communities, such as those in California, have used the windfall of tobacco dollars to finance innovative health-promotion activities and to coordinate services for families. This response may provide a model for other communities as they respond to the imperative to develop more responsive systems of care for young children and their families.

OVERVIEW OF VISITS TO PROGRAMS SERVING VERY YOUNG CHILDREN AND THEIR FAMILIES

The authors visited five agencies and their communities that serve very young children and their families. Four were funded by the Center for Mental Health Services as part of the Community Mental Health Services for Children and Their Families program. We selected these agencies because they offer mental health services to very young children and their families. The programs visited are the Children Upstream Project in Vermont; the Community Wraparound Initiative in Lyons, Riverside, and Proviso Townships, Illinois; KanFocus and Project Before in four counties in southeastern Kansas; the Kmiqhitahasultipon Program in Indian Township, Maine; and the Positive Education Program in Cleveland, Ohio. These programs represent a combination of rural and urban populations and serve children and families from a mix of socioeconomic and racial/ethnic backgrounds, mainly African American, American Indian, and European American.

For each program, the authors examined the operating philosophy of early childhood mental health services, the services offered, and the structure and financing. We found that organization, services offered, and funding sources varied among programs. The aim of this section is to provide a brief overview of the ways that these five communities offer early childhood mental health services and to discuss strategies and approaches that staff use to achieve promising practices in each agency. The practices we describe are not necessarily new to the field of Early Intervention (services to children with disabilities), but may be considered promising in early childhood mental health because they combine concerns with attention to healthy childhood development in the context of family and community. In each of the agencies serving very young children and their families, we found promising practices that can offer insights to those having a stake in the design and delivery of mental health services for very young children and their families.

Children's Upstream Services Project, Vermont

Individualized and Comprehensive Services

The State Team for Children and Families was developed in 1994 to increase state-level collaboration and to foster community partnerships with a view to developing a comprehensive response to the mental health needs of very young children and their families. Staff at Children's Upstream Services

Project have supported other child-serving agencies to further (and sometimes newly) develop mental health services. This development has included attention to specific services in a range of early childhood settings (e.g., how child care staff might work with a child facing mental health challenges).

Community-Based and Coordinated/Transdisciplinary Services

Stakeholders in children's mental health systems of care in Vermont have intentionally not built new systems and structures to serve very young children and their families. Instead, they have taken stock of what services exist and how different child-serving agencies are working with the mental health challenges that very young children face.

Community Wraparound Initiative, Lyons, Riverside, and Proviso Townships, Illinois

Individualized Services

Senior administrative staff members promote a state-level commitment to an individualized and wraparound approach and emphasize the benefits of this approach in the larger child-serving community. They focus on imparting the value of this commitment to all staff members by encouraging and supporting them as they implement this approach, even when that implementation is difficult and time-consuming.

Community-Based, Family-Centered Services with a High Degree of Family Participation

Staff members at the Community Wraparound Initiative worked hard, for an extended period, to develop a model of parent-to-parent support. They have fully implemented the roles of the family resource developers, who are family members of children who have received or are receiving services, are paid, and work full- or part-time. These staff members have been central to the program's success in serving very young children and their families. Family resource developers often live in the same communities as the children and parents who are receiving services.

Coordinated Services

Staff at the Community Wraparound Initiative who provide services to very young children have worked hard to develop and maintain links with informal and formal supports throughout the communities. They have invested in long-term relationships with staff at other agencies in the early childhood community and have built connections with informal support networks that exist on a neighborhood-to-neighborhood basis.

Kanfocus and Project Before, Southeastern Kansas

Individualized Services

Staff members at Project Before are especially attentive to how an individualized approach to the design and delivery of services might best meet the needs of the families they serve. Throughout the assessment and service delivery process, staff work with families to focus on strengths and to decide on and work toward particular goals and objectives. Parents have an important role in establishing priorities and in identifying strengths and needs.

Community-Based Services

Southeastern Kansas is largely rural. Families may live a considerable distance from a mental health center, or they may rely on public transportation. Offering services in the context of the home is particularly supportive to these families and allows the case manager to observe the family and child in the home environment.

Coordinated Services

The collaboration between the mental health program and Head Start offers a model for a range of agencies offering early intervention services. Staff members at Head Start have acquired useful information about children and mental health issues. Staff from the mental health center have built relationships with their educator colleagues and have benefited from the practices and philosophy of Head Start. In a broader sense, cross-agency work between these two agencies is a model for the larger child-serving community in southeastern Kansas. Similar relationships with public health have been a strong part of the Before Program.

The Kmiqhitahasultipon Program, Indian Township, Maine

Individualized Services

Staff at the Kmiqhitahasultipon Program are in a unique position to know their community well, and they pay close attention to culture. The program largely serves Passamaquoddy families, as well as children and parents who may be of European American or mixed heritage. Meaningful variations among and within these groups are taken into consideration in service planning and delivery.

Community-Based Services

Staff at the Kmiqhitahasultipon Program have intentionally built links with other child-serving agencies in the community, which has resulted in improved services for very young children and their families. For example, the parent advocate has worked with teachers and has intentionally worked to bring teachers and parents together. Parents now have a better understanding of the roles and responsibilities of teachers, and teachers have a better understanding of the mental health issues of children.

Coordinated Services

From its inception, staff members at the Kmiqhitahasultipon Program have attended to the importance of staff relationships and roles. An intensive five-day-a-week, four-week-long orientation and training program offers the staff a unique opportunity to learn one another's strengths and areas of contribution, as well as to focus on their collective vision and goals for the program itself.

The Positive Education Program, Cleveland, Ohio

High Level of Family Participation

The Positive Education Program uses a model in which family members are paid to work alongside professionally trained staff members. Family staff and professionally trained staff bring knowledge that is important to the design and delivery of services. Family staff are central to services; professionally trained staff serve as resources and support the work the parent staff are doing with other parents and children. Further, the parents of children currently receiving services have an important stake in the program.

Strong Focus on Needs, Strengths, and Resilience of Child and Family

In addition to focusing on particular developmental needs, staff at the Positive Education Program focus on health and well-being rather than on illness. Staff at the Early Intervention Centers, the Early Start Program, and Day Care Plus consistently work toward socially appropriate behavior. Parents whose children are receiving services work with parent staff and professionally trained staff to determine goals for the child and family.

Family-Centered Services

The Positive Education Program demonstrates a strong commitment to experiential-based services in which parents repeatedly interact with their children and receive support from Program staff. Even in our site visit to Early Intervention Services at the Positive Education Program, we did as much watching what happened as talking about what happened.

CHAPTER 1: INTRODUCTION AND LITERATURE REVIEW

With the increase in attention to children's mental health and the development of systems of care for children with serious emotional disorders and their families in the last two decades, mental health is emerging as a new focus in the field of early childhood. Developments in effective children's mental health services and family support programs have largely focused on the needs of school-aged children and adolescents, but increasingly, the mental health needs of children ages 0 to 5 are receiving attention from researchers, advocates, and service providers. Knowledge of healthy childhood developments and of the family and community conditions that support children's healthy development has resulted in efforts to promote family support and strong communities for all parents raising young children. At the same time, family members, practitioners, and researchers are becoming increasingly aware that mental health services are an important and necessary support for young children who experience mental, emotional, or behavioral challenges and their families.

In 1999, the Surgeon General's office called attention to mental health in general by publishing its first Surgeon General's report on mental health, with a full chapter devoted to children's mental health.

Concern about children's mental health and motivation for early intervention approaches are guided by the research finding that "at any given time, at least one in five children and adolescents may have a mental health problem that, without help, can lead to a variety of additional problems."[i]

The need for early childhood mental health services is clearly indicated by a recent study of more than 3,800 preschool-aged children that reported that 21 percent of the sample met the criteria for a psychiatric disorder and 9.1 percent met the criteria for a severe disorder.[ii]

Concern about children's mental health and motivations for early intervention approaches are guided by the research finding that "at any given time, at least one in five children and adolescents may have a mental health problem that, without help, can lead to a variety of additional problems."

Research and advocacy on behalf of those who receive mental health services have encouraged national, state, and local governments to set aside more funds to support the development and improvement of systems of care that serve children with emotional, behavioral, and mental disorders and their families. Service providers are becoming aware that very young children may need mental health services and that "it is a societal responsibility to provide needed early intervention programs for children with established disabilities and for those whose development may be compromised as a result of biological or environmental

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factors."[viii] Mental health services for very young children can benefit children who have difficulty developing age-appropriate social and emotional skills. Services can also benefit families, who are obviously critical to the development of young children, and in the long run can positively affect the entire community.[iv] The field of early childhood mental health provides opportunities to support child development and child-parent interaction as well as to respond to emerging behavioral, mental, and emotional challenges in very young children. These challenges may affect children from all socioeconomic and cultural backgrounds.

> The aim of early childhood mental health services is to improve the social and emotional well-being of young children and families by strengthening relationships with caregivers and promoting age-appropriate social and emotional skills.[v]

This monograph addresses promising practices in the delivery of early childhood mental health services for children 0 through 5 years of age and their families. In the sections that follow, we examine the literature to understand the explanatory theoretical frameworks that guide the field of early childhood mental health and the ways that knowledge and theory have influenced interventions at the policy, program, and practice levels. The literature review concludes with a synthesis of principles for the field of early childhood mental health that guided this study and the interview protocol for site visits to examine the implementation of promising practices in early childhood mental health services. Following a description of the study methodology, we present findings from our site visits to four Community Mental Health Services for Children and Their Families Program sites and one community-based initiative.

UNDERSTANDING EARLY CHILDHOOD MENTAL HEALTH

Changing emphases in policy and practices in early childhood mental health affect research and theory. In this section, we review the research and theory that help policymakers, program designers, and service providers understand the developmental needs of all young children and their families. An ecological-systems theoretical perspective directs attention to the way children and their families are embedded in their social and cultural communities and to the dynamic transactions between systems that shape their lives and experiences. All communities and systems have strengths and resources that can support children and their families, but they can also present challenges to well-being and healthy functioning. All families require support, informal and formal, to meet the challenging tasks of parenting in our complex society. Understanding the complex interplay of interactions that affect early childhood development and the ways that development is affected by environments may help shape more supportive general systems for families and their children and specific systems for effective intervention when challenges emerge. The ultimate goals of early childhood mental health services are to enhance the well-being of all children and to minimize and avoid behavioral problems in children with special needs.[vi]

The behavior of young children must be understood in the following contexts:

- An age-appropriate developmental sequence
- Relationships between children and caregivers in their immediate environment
- Factors in the broader environment that impact child-family relationships

Nurturing Environments for Young Children

Research and theory have drawn attention to the developmental tasks of infancy and early childhood and to the importance of nurturing environments and relationships that enable young children to maximize their potential for healthy development. Studies of infants and very young children have demonstrated that they actively use their senses and respond to caregivers from very early ages. For example, Brazelton and Cramer have described the earliest interactions between infants and their caregivers and the conditions that support healthy physical, emotional, and social development.[vii]

Devore and Schlesinger have identified the developmental tasks of infancy and early childhood, which are governed by physiological development. Stages of early childhood development are associated with particular tasks, including ensuring survival; establishing trusting relationships with caregivers; developing physical skills through motor activities and play; and acquiring language, cognitive skills, moral judgment, awareness of self, and social skills.[viii] Nurturing responses by caregivers contribute to children's healthy physical, emotional, and social development and support the emergence of skills and competencies. Caregivers' responses to young children's development and their capacities to nurture this development depend on their availability, expectations of childhood development, resources and support to meet children's needs, and cultural factors, which in turn are related to the environments in which they live. Developmental tasks are perceived and experienced in culturally specific ways common to each ethnic group. For example, contrasting practices of noninterference, protectiveness, and vigilance are seen as cultural dispositions to which children learn to respond in appropriate ways. Awareness of the importance of nurturing environments to support healthy development in early childhood increases awareness of the need of all parents and caregivers to have the resources and capacities to provide safety and care.

Understanding early childhood mental health also requires paying attention to the profound social and economic changes that have affected families over the last generation.

With changing family composition and changing demands on families comes increased stress.[ix] Growing numbers of parents are working, and often working more hours a week than in the past, to support their family. Data reported by the Children's Defense Fund indicate that in 1999, only 23 percent of all families with children younger than 6 had one parent who worked outside the home and one who stayed at home. Further, 64 percent of mothers with children under 6 are in the labor force. The number of children living in one-parent homes continues to grow, as does the number of children whose lives are affected in some way by substance abuse, mental illness, and HIV. The Children's Defense Fund reports the following findings about children: one child in six has no health insurance; one in seven has a working family member but is still poor; and one in thirteen is born with low birth weight.[x]

Further, because of the demand on parents to be in the work force, three out of five preschoolers are in child care every day. Of all children under 5, 41 percent spend 35 or more hours in child care each week.

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These findings demonstrate the changing social conditions that are affecting early childhood development and are increasing the stresses on children and their caregivers. They emphasize the need for research to guide the creation of healthy, nurturing environments for young children, whether they are in formal or informal day care or at home with a parent. The effects of stress and coping on parents and on children's mental, behavioral, and emotional health need further study. We also need increased attention to the social and environmental conditions and strengths that support nurturing by families.

The Ecological-Systems Perspective in Early Childhood Mental Health

The ecological-systems perspective has been influential in the field of early childhood mental health by providing a framework for viewing children's development and relationships in their family and social environmental contexts. Work by Bronfenbrenner on ecological theory and contexts of development has built a foundation for research and theory development that examine the variables related to the mutual transactions among child, family, and community.[xi] By directing attention to the different levels of systems with which families interact, Bronfenbrenner has broadened the focus to include the larger institutions and cultural contexts as well as the networks of personal transactions that shape children's lives and development. The ecological-systems perspective guides attention to transactions that promote healthy growth and development as well as transactions that ameliorate environmental conditions and relations that might be harmful.

Transactional models of child development, such as that proposed by Sameroff, see the child as a product of his or her dynamic interaction with the family and other components of the social environment.[xii] In this view, the family is the essential element in the child's caregiving environment.

> Families are more likely to interact positively with their children and meet their children's needs when both their relationships with their children and their interactions with others are satisfying.

Families are more likely to interact positively with their children and meet their children's needs when both their relationships with their children and their interactions with others are satisfying. Theoretical frameworks derived from family systems theory are a guide to understanding the structure, roles, values, beliefs, stresses, coping strategies, resources, and social supports of each family.[xiii] Patterson and McCubbin[xiv] and Dunst, Trivette, and Deal[xv] have directed attention to the positive effects of social support on the lives of families, family and child behaviors, and personal health and well-being. Further, a strengths perspective has been influential in early childhood mental health services in raising awareness of the strengths and resources in families and communities that can be harnessed to support caregivers and children.[xvi]

Research on Early Childhood Development

> New knowledge about brain development has begun to revolutionize the fields of children's mental health and early intervention and further underlines the value of intervening early in a child's life.

Recent research shows that early childhood is a critical period for supporting the mental, emotional, and behavioral development of very young children. Neurobiological research has demonstrated that such temperamental traits as activity level, adaptability, distractibility, attention span, and persistence are present in infants. Infants' and children's interactions with the environment in the form of their parents, caregivers, family, and community shape these genetically based characteristics of temperament, which in turn contribute to shaping the interactions.[xvii] Johnson describes the use of brain scanning techniques developed in the 1980s and refined in the 1990s to pinpoint the specific location of the source of emotional and behavioral disorders and to advance our knowledge about critical periods of brain development in infancy and early childhood. The structural organization and functional capabilities of the brain develop throughout life, but the majority of the critical structural organization takes place during childhood.[xviii] The number of connections in the cerebral cortex increases dramatically in the first few years of life. These increases are related to levels of glucose metabolism and result in the emergence of specific cognitive functions, such as language development and the ability to play a musical instrument, at specific ages.[xix]

> Recent research shows that early childhood is a critical period for supporting the mental, emotional, and behavioral development of very young children.

The plasticity of the brain refers to its ability to form new connections in the cerebral cortex and thereby overcome the effects of some kinds of brain injury; plasticity begins to decline after the age of 10, which again points to the importance of early intervention.[xx] Studies have shown that psychological damage early in life may be reversible if addressed within critical time periods. Differences in the effects of early deprivation may also be associated with temperamental differences and resilience.[xxi]

Less is known about emotional development in relation to brain development, but Johnson reports research findings that demonstrate associations among stress, maternal depression, and children's well-being.[xxii] Karr-Morse and Wiley have documented research demonstrating that intrauterine conditions and experiences in infancy that result in a child's inability to regulate strong emotions can lead to later violent behavior.[xxiii] They have drawn attention to research on early brain development that demonstrates that abuse and neglect in the early years of life (as well as exposure to toxins, such as alcohol and illegal drugs) affect the genetic, organic, and neurochemical foundations for impulse control and may result in later violent behaviors.[xxiv]

Perry, an expert on neurodevelopment, has studied the effects of chronic exposure to violence on children's neurological development.[xxv] He notes that during critical periods of cortical development, factors that increase the activity or reactivity of the brainstem, such as chronic traumatic stress, or that decrease the moderating capacity of the limbic or cortical areas, such as neglect, may increase the child's aggressivity, impulsivity, and capacity to display violence.[xxvi] Children exposed to intrafamilial violence are likely to develop persisting fear responses of physiological hyperarousal. Responses are marked by gender differences; girls are more likely to dissociate, whereas boys tend to develop aggressive, impulsive, and hyperactive symptoms.[xxvii] Perry has found that children who manifest these symptoms are often misdiagnosed as having attention deficit disorder with hyperactivity.

In their training and practice, the early intervention, pediatric, and child welfare fields have traditionally used descriptions of children's developmental milestones that include normal childhood development at each age and in several areas (e.g., fine and gross motor skills and adaptive, social, language, and play skills).[xxviii] Developmental matrices are often used in parent training to give parents reasonable expectations about their children's development at each age. Parents can also learn concrete ways to help their children acquire new skills. For example, a strengths-oriented model of child development used by child welfare staff in Oregon describes the general characteristics, skills gained, and educational and social tasks of each stage, as well as what the caregiver can do to meet the developmental needs of infants, toddlers, and older children.[xxix]

Theoretical concepts addressing the development of very young children, as well as ideas related to risk and resilience, have been particularly influential in guiding the development of early childhood mental health services. Research on developmental stages of children, as well as on brain development and the effects of violence on childhood development, is being used to guide interventions in early childhood mental health services.

Child development research has also contributed to an expanded consideration of children's development in a range of family and community settings and to increased attention to culture as it shapes children's interactions and development.

Risk and Resilience Frameworks for Understanding Early Childhood Mental Health

Program developers and service providers have used the concepts of "risk and protective" factors in two ways: to identify groups of children who are potentially most in need of services and to identify the kinds of strengths and social-environmental factors that mediate particular risks in a child's environment. Further, work on resilience has demonstrated how very young children with mental health challenges can overcome adversity without negative outcomes.

The concept of "at-risk" or "risk" factors has been prominent in the health care and prevention literature since the 1950s. Although a number of classification schemes have been developed to organize the variables that influence the way a child develops,[xxx] today's literature most often refers to two categories, risk factors and protective factors, sometimes labeled "risk and opportunity factors." Risk in this case refers to a characteristic of children (biological risk) or a characteristic in their environment (environmental risk; environment includes the context of family, community, or both) that previous research has associated with a negative child development outcome. In short, the "probability or chance that a poor or detrimental outcome might occur by definition defines a condition known as at-risk."[xxxi] A risk factor represents a probability that children with particular characteristics might experience a negative outcome, such as a developmental delay or a behavioral problem. The risk factor does not cause the negative outcome.

According to Kaufmann and Dodge, the literature on risk and protective factors makes three important points:

- Support and encouragement of protective factors and "amelioration of risks" can promote positive outcomes.
- An intervention that addresses several risks factors is more likely to result in a positive outcome than an intervention that addresses one or two risk factors.
- Interventions must address strengths and vulnerabilities at the individual, family, and community levels.[xxxii]

There is evidence that the presence of multiple risk factors is related to poor child outcomes. Specifically, exposure to any combination of three or more risk factors places children at increased risk.[xxxiii] For example, children born to poor mothers who have depression and abuse drugs or alcohol are at risk for developmental and behavioral problems. In early intervention and early childhood mental health services, risk factors have been used to target services to those families who are most in need and to focus limited resources. However, using risk factors to identify young children and their families as needing services is problematic because it fails to take account of child and family strengths and resilience and is fraught with cultural biases. Despite small differences, risk classification systems proposed in the first half of the 20th century and those used today are "much alike."[xxxiv] Iglesias and Quinn distinguish between labeling individuals "at risk" and identifying "at risk" groups. Legislation often points to statistically "at risk" groups (and defines these groups in racial/ethnic, economic, and linguistic terms). However, these authors point out,

> Too often in research and in practice it is forgotten that children are not "at risk" but rather that they are members of "statistically at risk" groups. Variations in skin color, wealth, and fluency in the language spoken by the majority are not, in and of themselves, challenging conditions to be overcome. By themselves, these characteristics present no risk for maladaptive behavior.[xxxv]

Being labeled as poor, as a drug abuser, as having a psychiatric illness, or as suffering from HIV carries heavy negative connotations that are difficult to reconcile with the emphasis in the children's mental health community on reducing the blame attributed to parents for their children's emotional or behavioral problems. Further, identifying families on the basis of their membership in a group with certain risk factors creates a barrier that providers must surmount to offer services from a strengths-based perspective.

The use of the at-risk category depends heavily on the social distance between those making referrals and doing the assessment and the child and family being assessed. Harry and Anderson assert that when teachers are not familiar with students' life experiences, "they often do not recognize that the knowledge and skills these students have gained from their experiences may be totally at odds with the knowledge and skills desired by the schools."[xxxvi] In an early childhood mental health context, a professional's lack of familiarity with a child's and family's background may lead him or her to concentrate on deficits (easily drawn from the behaviors identified as at risk) and miss strengths and resources, particularly when that background differs from the assessor's own. Moreover, the use of risk-factor classifications fails to take account of each child's unique set of circumstances and his or her unique protective factors and vulnerabilities, which are dynamic. Children may have periods when they experience more or fewer difficulties. Children who suffer through one or more vulnerabilities early in life may acquire strong coping skills for later setbacks.

Protective or opportunity factors are the characteristics of the child or of the child's environment that may protect the child from a poor outcome or buffer the difficulties the risk factors represent. These factors potentially decrease the negative influences in the child's life and enhance his or her ability to thrive. Researchers have identified protective factors associated with the child (e.g., the child's temperament), the child's family (e.g., parental social skills), and the child's community (e.g., support from adults in the community).

Protective or opportunity factors are the characteristics of the child or of the child's environment that may protect the child from a poor outcome or that buffer the difficulties the risk factors represent.

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A growing body of research evidence suggests that many children exposed to risk are able to overcome developmental hazards and adversity without apparent negative outcomes. This ability represents resilience, which researchers have conceptualized in a number of ways. One approach views resilience as coping, a process made up of four steps: (1) appraising the situation or event and determining its meaning; (2) selecting a coping strategy; (3) carrying out the strategy; and (4) evaluating the effectiveness of the selected strategy for eliminating or reducing the stressor or managing the response to it. Masten and associates have described three types of resilience. The first, often referred to as "overcoming the odds," is defined by the attainment of positive outcomes despite high-risk status. The second refers to "sustained competence under stress" and is related to children's capacity to cope with chronic environmental and interpersonal stress. The third concept of resilience refers to "recovery from trauma" and is defined as "successful adaptation despite adversity."[xxxvii]

Rutter sees resilience as protective factors, "influences that modify, ameliorate, or alter a person's response to some environmental hazard that predisposes a maladaptive outcome."[xxxviii] Studies of resilience in children have identified clusters of protective factors, including individual characteristics, such as a positive social orientation, and environmental characteristics, such as a warm, supportive home environment.[xxxix] These authors suggest that resilience is not a fixed attribute, but a dynamic characteristic that may emerge even after poor interim outcomes. Researchers have noted that broad definitions of resilience may obscure variations across different developmental domains of functioning and that culturally determined behaviors are a source of variation in outcomes.[xl]

Young children's social skills develop rapidly and have protective value by facilitating relationships with adults and other children. By encouraging parents to provide opportunities for young children to interact with peers and by monitoring and coaching appropriate interactions, professionals can help parents enhance their children's social competence. Interventions at the family level are designed to enhance parenting, improve social support, and help parents reduce the stress in their lives by enhancing their own coping skills.[xli]

> By encouraging parents to provide opportunities for young children to interact with peers and by monitoring and coaching appropriate interactions, professionals can help parents enhance their children's social competence

Professionals in early intervention and children's mental health are increasingly emphasizing resilience and protective factors as they search for more effective strategies to assist young children and their families who have been exposed to early and multiple risk factors. High-quality early childhood programs may protect children from the effects of exposure to risk factors and may also create or enhance protective factors for children considered to be at risk of emotional or behavioral disorders.[xlii]

For example, Karr-Morse and Wiley note that early intervention can modify or prevent many of the factors contributing to later violent behaviors.[xliii] Interventions developed from a protective-factors perspective strengthen positive parent-child relationships; support effective parenting as a way to give children successful role models; and provide opportunities for children to experience mastery, competence, and increased feelings of self-efficacy.[xliv] Four general categories of interventions to promote resilience are enhancing self-esteem, improving academic achievement, promoting social skills, and strengthening families and social supports.[xlv]

To enhance children's self-esteem, professionals often use psychoeducational strategies with parents to increase responsive parenting and to encourage parents to provide opportunities for children to develop skills and competencies. Strategies to enhance the social support available to families can directly and indirectly affect children's healthy development and behavior and can serve as buffers against life stressors. The presence of at least one caring, supportive adult has been consistently identified as a protective factor for children across a variety of risk conditions.[xlvi]

> Four general categories of interventions to promote resilience are enhancing self-esteem, improving academic achievement, promoting social skills, and strengthening families and social supports.

Knitzer identified communities where approaches that build on resilience and protective factors are in place.[xlvii] For example, in Stark County, Ohio, the Preschool Assertiveness Community Team (PACT) program provides individualized (wraparound) interventions in the home and in the local Head Start program with children identified as being at risk of developing emotional or behavioral problems and their families. The Smart Start Initiative in North Carolina is a multiagency, collaborative effort to expand child care services to low-income children and to encourage comprehensive services. Dollars saved by avoiding hospitalization for older children are being reinvested in outreach to the early childhood community. In Ventura County, California, a promising program for improving early childhood mental health is infusing a mental health perspective into all aspects of a Head Start program, instead of viewing mental health services as a stand-alone component. The well-developed system of care for older children has helped the Head Start community obtain resources and has placed mental health professionals on site to support family service workers and classroom teachers and to direct services to families.[xlviii]

Evaluation research shows that intervention programs that offer support services to high-risk children and their families can be of great benefit by providing protective functions and promoting positive outcomes.[xlix] An example of an early childhood program that supports resilience and protective factors is the Twenty-First Century School Model.[l] By providing reliable, affordable child care that includes family support and is individualized to meet the unique needs of families, this model has had positive effects on school readiness, student achievement, and relationships between parents and children and parents and school personnel. The Healthy Start program developed in Hawaii and replicated in other states demonstrates the positive outcomes of an intensive home-visiting program with parents of infants that is designed to support the resilience and protective factors in families.[li] Weissbourd notes that Hawaii's Healthy Start led to marked drops in rates of neglect and abuse, increased immunizations rates, and evidence that participating children enter school ready to learn. Further, "evaluations indicate that home visiting can reduce the number of children suffering cognitive and developmental delays and improve mother-child interactions and various health outcomes."[lii]

Other examples of successful programs that support the resilience and protective factors in young children and their families include the Resource Mothers program of South Carolina's Division of Maternal Health[liii] and the Perry Preschool Project in Ypsilanti, Michigan.[liv] In the Resource Mothers program, older, experienced mothers are linked with teenage girls during pregnancy to develop trusting relationships and transmit knowledge and skills about parenting, health, nutrition, child development, and community resources throughout the early years of raising children.[lv] The Perry Preschool Project began in 1962 to foster the social and cognitive development of African American preschool children who were seen as at risk of school failure. Evaluation data indicate that positive outcomes persisted into young adulthood. For example, the high school graduation rate of program participants was 33 percent higher, their arrest rate was 40 percent lower, and their teen pregnancy rate was 42 percent lower than those of their control group. At age 19, twice as many program participants were employed, attending college, or receiving further training compared with their control group peers.

This summary of the literature on early childhood development and early childhood mental health leads to a number of conclusions. The research and theoretical developments described here point to the importance of creating nurturing environments for all families and young children and to the need for supporting all families, but especially families whose children have or are at risk for developing serious emotional disorders.

The growing attention to the socioeconomic, cultural, and environmental contexts in which children develop has resulted in the emergence of interventions to support families and to take account of their unique needs and strengths. New knowledge about early childhood development, the effects of risk factors, and the resilience of children has focused attention on the potential benefits of early intervention.

The research and theoretical developments described here point to the importance of creating nurturing environments for all families and young children and to the need for supporting all families, but especially families whose children have or are at risk for developing serious emotional disorders.

EARLY CHILDHOOD MENTAL HEALTH: POLICIES, PROGRAMS, AND PRACTICES

Research findings about early childhood development and the biopsychosocial factors contributing to emotional, behavioral, and mental health disorders have shaped policy, program, and practice responses designed to promote healthy development, support families, and intervene therapeutically where concerns have been identified. Current early intervention efforts have been guided by an agreement among professionals, parents, policymakers, and advocates that "the early years constitute a unique opportunity for influencing child development and supporting families, an opportunity that may well maximize long-term benefits for all concerned."[lvi]

Policies Related to Early Childhood Mental Health: An Overview

Policies directly relevant to early childhood mental health services address early intervention with young children with disabilities, education for children with disabilities, child welfare legislation, health care for low-income children, and welfare reform. Legislation passed in the 1960s underscored the emerging belief in the importance of early intervention with young children. Head Start was established in 1964 under Public Law (P.L.) 88-452 and represented the first national attempt to intervene directly with young children.[lvii]

Part of the "war on poverty," Head Start had the goal of improving the development of disadvantaged low-income children through a combination of services: early childhood education, health screening and referral, mental health services, nutrition education and hot meals, social services for the child and family, and parent involvement and training. The basic Head Start program is a center-based preschool serving children ages 3 to 5 from primarily low-income families. Typically, children attend half-days for one school year, although some children attend for two years.

Although each program must adhere to national performance standards in the six areas, centers are encouraged to adapt their program to respond to local needs and resources. From the beginning, parent involvement has been a central feature of Head Start, with parents participating in planning, administration, and daily activities at the local center.[lviii]

Each Head Start program has six components: early childhood education, health screening and referral, mental health services, nutrition education and hot meals, social services for the child and family, and parent involvement.

Over the last three decades, political commitment has wavered from time to time, leading to underfunding, which has limited the number of eligible children who have been able to participate in the opportunities Head Start provides. Despite these limits, by 1993, almost 1,400 Head Start grantees were serving 721,000 children and their families.[lix] Head Start has been remarkable because it changed the nation's patterns of preschool education and the treatment of economically disadvantaged children.[lx]

Public Law 90-248, passed in 1967, established Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) programs as a component of Medicaid. These programs identify and treat low-income children "early" to prevent developmental and medical problems. Under EPSDT, young children who are screened by a medical provider and are identified as needing physical or mental health treatment must be provided with treatment. As a result, children from low-income families are now more likely to be referred for mental health treatment at an earlier age and at an earlier stage in the emergence of their mental disorder.

Public Law 90-538, passed in 1968, established the Handicapped Children's Early Education Assistance Program, the first special education program directed specifically toward young children with disabilities. In 1975, Congress passed P.L. 94-142, the Individuals with Disabilities Education Act, which recognized that all children with disabilities should have educational opportunities and gave parents the right to be involved in their child's Individualized Education Plan. The Education of the Handicapped Act, P.L. 98-199, was signed into law in 1985 and provided funds for services for children ages 0 to 5 with disabilities and their families. This legislation was significant because it acknowledged that the complex needs of children with disabilities and their families require comprehensive approaches and it provided funds for states to plan, develop, and implement comprehensive services. In 1986, P.L. 99-457, the Education of the Handicapped Act, increased access and funds for early childhood services for children ages 0 to 5 with disabilities and their families. Further, the Act called for family participation in the development of Individualized Education Plans (IEPs) and Individualized Family Service Plans (IFSPs). This law reiterated the need for family involvement and strengthened the emphasis. Five years later, the Education of the Handicapped Act was modified and renamed the Individuals with Disabilities Education Act (IDEA) of 1991. These legislative changes have been significant because they have given hundreds of thousands of young children with disabilities and their families access to services with family participation in decision making.

Two programs were established as a result of P.L. 99-457. Part H of the Individuals with Disabilities Education Act, the Infants and Toddlers with Disabilities Program, serves children from birth to age 3 with disabilities (or who are at risk of developing disabilities) and their families. Part H of the Individuals with Disabilities Education Act (now referred to as Part C under the 1997 reauthorization) broadens the focus of service planning and mandates that a multidisciplinary team and the parents develop an Individualized Family Service Plan (IFSP) for each child and family. This represented a significant move toward family-centered practices. Part H was innovative in its emphasis on early intervention services driven by the needs of families.[lxi] Helton states that Part H of the Individuals with Disabilities Act "has brought parents into a new era—one in which they are being asked to share with professionals their own expectations and priorities through direct participation in developing and implementing educational and supportive service plans."[lxii]

Shifting emphases in child welfare policies and practices over the last two decades are also relevant to early childhood mental health services. In response to growing concern about the increasing numbers of children remaining in foster care for extended periods, Congress enacted the Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272). This legislation requires child welfare agencies to make "reasonable efforts" to prevent children from entering foster care and to undertake permanency planning to seek stable, long-term homes for children who do enter foster care.[lxiii] The Homebuilders model of short-term intensive family preservation services in Tacoma, Washington, represents a shift in the child welfare paradigm from protecting the child through removal from the family to changing the family dynamics to safely nurture the child.[lxiv] The Homebuilders model is based on Bandura's social learning theory and focuses on cognitive and behavioral training in effective parenting, emotional management, interpersonal skills, and assertiveness training.[lxv] Developers of the Homebuilders model evaluated their own practice and found promising results related to specific outcomes.[lxvi] Many child welfare systems across the country embraced the principles of Homebuilders and replicated the intensive family preservation programs. Title IV-B of the Omnibus Reconciliation Act of 1993 (P.L. 103-66) provided $1 billion to the states over five years for early intervention, prevention, and family support services.[lxvii]

Helton states that Part H of the Individuals with Disabilities Act "has brought parents into a new era—one in which they are being asked to share with professionals their own expectations and priorities through direct participation in developing and implementing educational and supportive service plans."

The mixed results from subsequent evaluations of intensive family preservation programs tempered enthusiasm for these services. Replicating the model in public child welfare agencies proved challenging, and variations occurred in the intensity of services offered to families.[lxviii] Although the Homebuilders model called for high-intensity services delivered by highly trained, experienced professionals, parent advocates, and aides with small caseloads and frequent group supervision, the replications used less well trained staff, larger caseloads, and less close supervision. Wells has noted the challenges of replicating any innovative model and points to three critical issues: "one, the implementation of the treatment that is planned on a case-by-case basis; two, the nature of the facilitators of, and the obstacles to, implementation of the model in varying agency, service system, and community contexts; and three, the size of the population of children in the child welfare system whose families would qualify for Homebuilders-type programs."[lxix]

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The combination of ambiguous evaluation findings from comparison studies of multiple programs, a number of highly publicized child abuse incidents, and diminishing public support for the kinds of services that families needed; such as mental health and substance abuse treatment, swung the pendulum away from family support in child welfare and toward a narrowed focus on child protection.[lxx]

The trend toward family support in the community has been overtaken by legislation imposing strict timelines for permanency planning and termination of parental rights under the Adoption and Safe Families Act of 1997, P.L. 105-89. The Act's goals of safety, permanency, and well-being for children in the child welfare system have led to an emphasis on collaborative, multidisciplinary, developmental approaches to meeting the needs of children, taking account of the high rates of medical conditions, prenatal exposure to drugs and alcohol, developmental delays, and mental health problems among preschool-aged children being placed in foster care.[lxxi] The needs of young children are a particular concern, since children under 6 represent the most rapidly increasing group of children being placed in foster care. Concerns have been expressed particularly about family members whose children are in foster care while they are in substance abuse programs. These parents may need more time than the Act allows to successfully complete a substance abuse program, completely stop using drugs and alcohol, and be judged able to care for their children. This may result in separation of parent and children with even more adverse effects on the mental health of the children.

Although the Adoption and Safe Families Act aims to improve children's safety, promote adoption, and support families, research on how these objectives are reached for specific populations (especially parents with mental health, alcohol, and substance abuse problems) will be important as the Act is put into practice. For example, parents whose children are removed because of parental substance abuse have difficulty accessing appropriate residential treatment that includes their children. The time line introduced by the Adoption and Safe Families Act may be too short.

The requirement to terminate parental rights also has particular significance for children of color. As Dodson reports,

> Children of color, particularly African-American children, are disproportionately represented among foster children awaiting adoption and are placed in foster care in disproportionate numbers. Their families receive fewer services than white families, and they have longer stays in foster care. They are adopted at lower rates than their representation in the foster care population, despite African-American families adopting at higher rates than others, and thus wait to be adopted longer than white children.[lxxii]

For low-income children and their families, the Personal Responsibility and Work Opportunity Reconciliation Act ("Welfare Reform") of 1996 has had a significant impact. Parents of young children are now compelled to enter the work force after the expiration of time limits for receiving public support funds.

Aid to Families with Dependent Children (AFDC) has been replaced by Temporary Assistance to Needy Families, which has strict time limits for receiving assistance. The availability of federal funds to provide child care assistance to low-income families moving from welfare to work has been increased, and funds have been set aside for quality improvements to child care. As a result of this legislation, as well as of the growing numbers of mothers in the workforce generally, day care is gaining a good deal of attention from researchers and policymakers. Zigler and Gilman note the tremendous beneficial impact of good early care and education on children and their later cognitive abilities.[lxxiii]

However, these authors note that "the absence of an adequate child care system, as well as the other current social conditions, places a great emotional and economic strain on parents who are compelled to juggle work and family responsibilities without the assistance of a supportive infrastructure."[lxxiv]

The generally poor quality of day care available to many young children, with its potentially damaging effects on early childhood development, is of great concern. Schorr cites a General Accounting Office report that confirms that federal child care subsidy programs emphasize parental employment over child development, with subsidies too low to cover the cost of centers that provide high-quality, comprehensive services.[lxxv]

Zigler and Gilman note that "the absence of an adequate child care system, as well as the other current social conditions, places a great emotional and economic strain on parents who are compelled to juggle work and family responsibilities without the assistance of a supportive infrastructure."

Additionally, the mental health needs of their children may seriously stress many mothers leaving welfare, which may affect their capacity to participate fully in the workforce. In one of the first studies of women leaving welfare, Boothroyd and Olufokunbi found that more than one-quarter of the children whose mothers were currently participating in the welfare program and those who had left the program in Florida had significant mental health problems.[lxxvi] If these data are found to represent former welfare recipients in other states, they will support the need for expanded services in children's mental health and early intervention.

Finally, the Children's Health Insurance Program (CHIP) is another policy development that influences early childhood mental health services. CHIP was created in 1997 to expand health insurance coverage for uninsured children. This program's outreach efforts are identifying Medicaid-eligible children and enrolling them in Medicaid or states' health insurance programs. States may now pay community mental health centers to expand coverage for children for mental health services. The legislation also requires states to provide Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services to all children covered under Medicaid. The legislation benefits low-income children with mental health conditions because states that offer non-Medicaid Children's Health Insurance Programs that include mental health services must comply with the Mental Health Parity Act (MHPA) regulations of 1996. However, the regulations are complex in regard to low-income children who require inpatient mental health treatment, and there are concerns about the return of unspent funds by states that have chosen to not fully implement the program.

The Children's Health Act of 2000 combined several bills in support of children's health. In particular, this Act reauthorized the Substance Abuse and Mental Health Services Administration, the federal agency responsible for providing mental health and substance abuse treatment and prevention for children, adolescents, and adults. The Act also offers a sixth year of funding to the systems of care funded through the Community Mental Health Services for Children and Their Families Program, which will directly affect children ages 0 to 5 and their families. Other provisions in the Children's Health Act relevant to the field of early childhood mental health include up to $50 million for programs that focus on the behavioral and biological aspects of psychological trauma and up to $10 million to provide integrated child welfare and mental health services for children in the child welfare system.

The developments above in early childhood legislation and policy illustrate the complexity and fragmentation associated with mental health service delivery for young children.

> There is clearly a need for early childhood programs that coordinate services across agencies, that treat the child within the context of family and community, and that involve family members in significant ways.

The policies described in this section place the development of early childhood mental health services in the larger context of public support for very young children. National policies affect the importance that state and local levels attach to services and can lead to improved mental health services for very young children. New sources of funding and federal mandates have resulted in growing attention to meeting the needs of young children and their families. In addition, policy-level changes have shaped the kinds of interventions offered at the local level to address the developmental needs of children in their family and community context. In some settings, policy-level mandates give greater voice to parents and caregivers in decisions about their children's education, care, and treatment.

Early Childhood Mental Health Program Responses

Program developments in early childhood mental health services have been guided by research showing that early intervention can systematically reduce later developmental challenges for children when the interventions are offered during the first five years of life. The field of children's mental health is beginning to recognize the need to provide support to all children and families, including those ages 0 through 5. Early childhood mental health can be a critical source of support for very young children who have emotional and behavioral challenges and their families, and research indicates that early diagnosis and intervention can result in what parents and providers perceive as positive outcomes for these children. Early childhood programs that integrate a mental health perspective focus on prevention and engage in the following activities:

- Anticipating and promoting children's well-being, rather than responding exclusively to identified problems
- Reaching out to children at risk of developing emotional and behavioral difficulties
- Acknowledging that some young children have identifiable disturbances and are seriously troubled
- Viewing parents and other caregivers as integral to promoting the mental health of all children, but especially those with identified behavioral problems[lxxvii]

Research shows that early intervention can systematically reduce later developmental challenges for children when the interventions are offered during the first five years of life.

Despite increasing support for mental health for very young children and their families, services are highly variable across communities, may differ among agencies that serve very young children, and can be fragmented. Within mental health systems of care serving children and adolescents with emotional and behavioral challenges and their families, the expansion of services would more fully address the needs of very young children and their families. In the early childhood community, some child-serving agencies currently place relatively low importance on mental health issues. Supports and services are needed for families with young children who are dealing with specific challenges, such as substance abuse and mental illness. For example, Zuckerman and Brown draw attention to the needs of mothers of young children who abuse substances: "Programs need to be developed that treat women within the context of their families. Infant mental health specialists can help the addiction specialists understand the mothers' interest in their children, and thus provide a special window of opportunity to reach the mothers."[lxxviii] Another critical area in early childhood mental health services is attention to culture and cultural differences.

Diagnostic Tools Used in Early Childhood Mental Health Services

The development of diagnostic categories specifically for very young children has been an important element in early childhood mental health service delivery. However, tensions have arisen from the conceptual differences between service provision driven by diagnosis and the prevailing emphases on ecologically guided family support approaches and preventive services guided by risk and resilience frameworks. Some clinicians believe that informal, unstructured conversations with families may be more informative than formal measures. At the same time, funding mandates often require formal diagnostic tools.

Diagnostic tools that have been developed for children who are older than 5 are not always immediately useful for very young children. Parents and providers may be reluctant to diagnose children when they are so young; labeling a child of any age is difficult, but it is a particularly sensitive issue when the child has not even reached school age.

> Ideally, diagnosis of very young children will not only address the child's need for treatment, but also maximize the child's strengths as part of the overall intervention.

Careful and thorough diagnosis that takes into account the effects of traumatic events and the environmental and cultural factors that affect the ways young children manifest distress is critical to early childhood mental health services.

The most commonly used diagnostic system in children's mental health is the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (DSM-IV), published by the American Psychiatric Association.[lxxix] Although designed as a multiaxial system to facilitate "comprehensive and systematic evaluation with attention to the various mental disorders and general medical conditions, psychological and environmental problems, and level of functioning,"[lxxx] the DSM-IV has been criticized because of its limitations in accurately diagnosing young children's mental health problems and because of its cultural biases.[lxxxi] Cervantes and Arroyo note that the DSM-IV's process of categorization "becomes progressively more difficult in younger age groups, where children are less able to clearly articulate their feelings and emotions and such states can only be inferred from adult reports or observable behaviors."[lxxxii]

Cervantes and Arroyo have examined the application of DSM-IV with Hispanic children and identified ways that specific diagnoses are likely to be culturally biased, which can lead to misdiagnoses and errors in the treatment of Hispanic children.[lxxxiii] These authors emphasize the importance of attention to psychosocial stressors, including language barriers, discrimination, and value barriers in diagnosis. They recommend qualitative descriptions of these issues in assessment to enable mental health providers to intervene more appropriately with young Hispanic children.[lxxxiv]

A diagnostic tool designed specifically for very young children is known as Zero to Three. According to the authors of *Diagnostic Classification: Zero to Three*, formulating diagnostic categories for very young children can (1) provide a way for clinicians and researchers to organize what they observe; (2) help providers and clinicians assess the child and develop recommendations for possible intervention and support; (3) offer a common language for a range of stakeholders in the field of early childhood mental health; and (4) provide an initial framework "from which further refinements and changes can be made."[lxxxv]

The Zero to Three classification tool for infants and the very young assesses physiological and emotional development, the child's relationships, and environmental and psychosocial contexts. This assessment tool describes a set of symptoms or behavior patterns instead of determining etiological or disease-based explanations.

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The tool consists of five axes that assess "all relevant areas of a child's functioning."[lxxxvi] Axis I identifies the primary disorder(s), including traumatic stress disorder, adjustment disorders, regulatory disorders, sleep disorders, eating disorders, and disorders of relating and communicating (developmental). Axis II describes the child's relationship abilities or deficits with primary caregivers. Medical conditions are defined in Axis III. Axis IV describes the child's psychosocial stressors, such as death of a parent or adoption, and their effect on behavior. Level of emotional development is defined in Axis V.

A full evaluation takes three to five 45-minute sessions and results in a well-described pattern of strengths and challenges in all areas of functioning and development, including social-emotional functioning and relationships and cognitive, language, sensory, and motor abilities compared with the norm for that age group. Part of the initial assessment focuses on psychosocial history, medical history, prenatal and delivery information, and current environmental conditions and stressors. An assessment of family and child history, in combination with observation and standardized developmental assessments, can provide a comprehensive picture of the child's difficulties and strengths, which is useful when planning a comprehensive and effective intervention.

Although the tool is designed to assess children, it also aids in forming preliminary conclusions about the needs of the family. For example, information from the Axis II Relationship Classification can help parents better understand how they can best support the child to reach specific goals, and it can help parents identify and practice developmentally appropriate expectations for the child. The assessment might also help parents identify how they can be more responsive to the child's needs. Improving the quality and quantity of the positive attention the parent gives to the child is likely to have direct benefits for the child. The assessment assumes, then, that the best intervention for a child often includes interventions designed to support the entire family.

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Family-Centered Program Developments in Early Childhood Mental Health

Meeting the emotional, mental, and behavioral needs of children ages 0 through 5 requires collaboration among mental health programs, providers, and early childhood agencies, and it calls for knowledge of mental health and child development issues specific to very young children. In addition, the complex issues facing many families require coordinated responses by multiple professions and disciplines working in multiple systems. With regard to the needs of children with HIV infection and their families, Woodruff and associates recommend using transdisciplinary and transagency models of intervention, which also have benefits in early childhood mental health services.[lxxxvii] The transdisciplinary approach is a holistic approach to intervention in which families are members of the service delivery team. Services to the child and family are planned by the transdisciplinary service team and approved by the family.[lxxxviii] The transagency model coordinates the services of the multiple agencies that serve the child and family. According to Woodruff, the model effectively streamlines community services for children and families who receive support from a variety of agencies and practitioners.[lxxxix]

Family-centered early intervention services are based on two assumptions:

1. The need for interdisciplinary activity to meet the diverse needs of children and their families
2. The need to consider the needs of young children in the context of the family and community

These ideas have been influential in early childhood mental health. In recent years, family involvement in children's mental health and early intervention services has increased dramatically, in part because of legislation supporting family participation and family-centered services. In addition, family advocacy organizations have pressed for greater involvement at all levels in decision making related to children's treatment and care.[xc]

The incorporation of research on the transactional nature of development and of ecological, family, and social support theory into early intervention program practices has also contributed to increased parental involvement. According to Wehman, families are now viewed as essential members of the early intervention team, with roles in planning interventions for their child and providing services through training, teaching, and therapy.[xci] In a parallel development in early childhood mental health, professionals are moving to a view of families as the ultimate decision makers about services their child receives and are beginning to direct services to the family.

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Innovative Programs in Early Childhood Mental Health: Examples from the Literature

Although principles of family-centered early intervention are gaining acceptance across the nation, variations exist in the extent to which family-centered principles drive the implementation of early childhood mental health programs and services. Researchers have described a number of innovative and model early childhood programs, and their findings have implications for early childhood mental health.

In a study of early intervention program components, Guralnick found that they increasingly comprise three major features: resource supports, social supports, and information and services. He suggests that "if properly accessed, sequenced, and coordinated," such programs "appear capable of mitigating many of the stressors associated with a child's biological risk and disability status."[xcii] Stayton and Karnes surveyed 34 early education programs for children with disabilities and compared the results with an earlier survey.[xciii] They concluded that birth-to-3 programs are becoming more comprehensive in their delivery of services to children and their families. They also found more collaboration between university medical and educational programs, increased implementation of team models and practices, greater adherence to philosophical models that focus on parents and other family members as well as on the child, and more systematic practices in the individualized family service plan process. Koyanagi, Feres-Merchant, and Schulzinger point to the lack of a comprehensive system of services for young children and their families and present an example of the kinds of services and supports that are most helpful to parents of young children with mental, emotional, or behavioral disorders or at risk of developing these conditions (see box).

SERVICES AND SUPPORTS FOR VERY YOUNG CHILDREN

- Prevention and early identification services: Outreach, risk assessment, screening, prenatal care, substance abuse prevention, parent education activities, pediatric services, and caregiver consultation and training
- Outpatient services: Assessments, evaluation, and diagnosis; intensive in-home services; crisis services; individual or family therapy; mental health services for children with parents who are mentally ill; substance abuse outpatient services; other substance abuse treatment and support services; and medication management
- Intensive community services: Specialized day care, therapeutic nurseries or preschools, therapeutic foster care, substance abuse services for children of drug- or alcohol-related parents, and physical and speech therapy
- Residential services: Substance abuse programs for women with young children and substance abuse detoxification
- Family support services: Case management and service coordination, respite services for families, and transportation

Excerpted from Koyanagi, C., Feres-Merchant, D., & Schulzinger, R. (1998).

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Zigler and Gilman have described The Twenty-First Century School Model as a stable, reliable, and affordable child care system that includes family support and is flexible enough to meet the unique needs of individual families.[xciv] The model features a regular school during usual school hours, together with a child care and family support system that operates year-round from 7 a.m. to 6 p.m. and is open to children age 3 and up for parents who require supplementary child care.

THE TWENTY-FIRST CENTURY SCHOOL MODEL

The program offers developmentally appropriate, high-quality care for preschool children, supervised recreational programs for older children, and three outreach components. The first is parent education and family support provided through home visiting (home visits include health screening, parent education, and inoculations for children). Second, the program organizes family day care homes in a community into a network with the school as its hub; the school then offers training, monitoring, and support for family day care workers. Third, the program provides a resource and referral network to help families more easily gain access to the services available in their community. Some sites have also adopted a fourth outreach component, which offers a school health center for families that provides well-baby care, health screening, health emergency services, dental and developmental assessments, and mental health services.

Zigler, E. F., & Gilman, E. D. (1998), p. 484.

As of 1998, this model had been implemented in more than 500 schools in 17 states. An evaluation of the oldest site, in Independence, Missouri, shows that the program has helped reduce parental stress. Further, the percent of parents who miss work because of child care difficulties has been reduced from 30–40 percent to zero. The program has also had positive effects on school readiness, on student achievement, and on relationships between parents and children and parents and school personnel.

Lequerica has proposed a community-based, comprehensive, holistic, and coordinated model of service to low-income preschoolers and their mothers.[xcv] This model would be accessible from one facility provided by an existing community-based agency, such as a pediatric clinic; targeted to services for the whole child; interdisciplinary in nature, with a team approach coordinated through advocacy; and effective in follow-up activities.

Golly, Stiller, and Walker describe The First Step to Success program.[xcvi] This secondary prevention intervention targets at-risk children in kindergarten who show signs of developing antisocial behavior patterns. The program has three components: an early screening module; a school intervention module that teaches target children adaptive behaviors that promote academic success, teacher acceptance, and the development of peer friendships; and a parent training module that enlists parents as partners in teaching skills for school success to target children at home.

After describing an investigation of the replicability of the program, Golly, Stiller, and Walker conclude that participants in program workshops who did implement the program said that it was effective in teaching appropriate behavior, had a positive effect on the target child's peer relations, and was relatively easy to use and manage as part of general teaching duties. A limitation of the study is that it had no control group for comparison. Golly, Stiller, and Walker note that many school personnel are reluctant to invest in effective early intervention programs unless the target child has serious behavioral problems. Some students with mild behavior problems are not referred to appropriate interventions, services, and supports until the challenges the child is facing have escalated significantly. For effective outcomes with young children at risk for antisocial behavior patterns, they believe that it is essential that a child demonstrating challenging behavior be identified for intervention as early as possible in the child's school career.[xcvii]

Project Star, a program of the Foundation for Children with AIDS, offers an example of a comprehensive program for children born with HIV/AIDS and their families that helps them remain together. Central to the philosophy and structure of this program is broad use of a transagency/transdisciplinary model. The transagency case management model "coordinates services for children and families who are receiving support from a number of agencies." Representatives from different agencies serving the child(ren) and family participate in a case management team and carry out a service plan that "coordinates services across their agencies." This model incorporates a transdisciplinary approach, in which team members, working within the same program, design and implement a service plan that cuts across their different disciplines.[xcviii]

Project Star provides therapeutic intervention and a full-day developmental program for approximately 64 children ages 0 to 5. In addition, the program provides education, health, case management, and psychosocial home- and center-based services for the family, as well as family support for all family members. The program primarily serves African American and Latino/Hispanic families and is located in an inner-city neighborhood of Boston. Project Star won national recognition and was cited by the Surgeon General as an exemplary family-centered and community-based program worthy of replication.[xcix] This model of transagency/transdisciplinary services is entirely compatible with System of Care principles developed by Stroul and Friedman.[c]

The Elmira Prenatal/Early Infancy Project was designed to enhance health, social well-being, and mental health in infants from young, low socioeconomic, and single-parent families. Four groups were randomly assigned to receive four interventions. The first intervention was screening of children at ages 1 and 2. The second group received screening and free transportation to health care. The third group received screening, transportation, and nurse home visits to pregnant women once every two weeks. In addition to those three interventions, the fourth group continued to receive nurse home visits after the birth of their children.

Longitudinal follow-up studies over 15 years indicated that women visited by a nurse both during and after pregnancy had a lower incidence of child abuse, cared for children who had fewer behavior problems, and were more involved with their children than comparison group mothers. Thirteen years after birth, compared with children in the groups that had received only screening or screening and transportation, these children had fewer reported instances of running away, fewer arrests, fewer convictions, fewer lifetime sex partners, fewer cigarettes smoked a day, and fewer days with alcohol consumption within the six months prior to follow-up. Parents reported fewer behavioral problems than those from the control groups. A cost benefit analysis estimated that the costs of the program were more than offset by the higher taxes paid by the women and by projected savings for community interventions. These interventions may have included Aid to Dependent Families with Children, food stamps, child protective services, and Medicaid.[ci]

Stayton and Karnes recommend that communities that wish to improve their services for young children adopt models whose effectiveness has been demonstrated.[cii] Zigler and Gilman commend the excellent universal preschool programs that are being developed in some states, but urge a national child care allowance that would either permit parents to remain at home to care for their children for the first year of life or help defray the costs of child care.[ciii] Zigler proposes a three-phase strategy to enhance the capacity of early intervention programs to help children living in poverty: (1) a parent-child program that begins prenatally and continues through age 3; (2) quality preschool services that overlap with entry to elementary school and ensure a smooth transition; and (3) dovetailed services that continue from kindergarten through grade 3.[civ] Each phase would provide health and nutrition, developmentally appropriate social and educational experiences, and quality child care (if needed). Parents would be involved in the program and would receive parenting education and family support to promote healthy family functioning. This strategy is also likely to address potential or existing mental health needs among young children. These kinds of holistic approaches to serving young children and their families offer valuable ideas for early childhood mental health.

The Need for Evaluation in Early Childhood Mental Health Services

The development of more effective strategies for early childhood mental health services will require committing resources to evaluate programs, practices, and outcomes for children and their families, which to date have received only limited attention. Knitzer points to the need for systematic evaluative studies in early childhood mental health services, with particular attention to the impact of managed care on improving mental health services to young children and their families.[cv] Guralnick makes a case for efficacy research in early intervention to justify continued financial support for existing services and to fund expanded services; his recommendations should be heeded by the childhood mental health community.[cvi]

Although evaluations of the effectiveness of early childhood intervention programs have found variable results, Guralnick argues that contemporary developmental theory can provide a useful framework for examining the array of services and reconciling apparently conflicting findings.[cvii] In an examination of the effectiveness of early intervention programs for children with developmental disabilities and biological risks, Guralnick reports that intervention initiated very quickly may be effective because it prevents the development of cumulative deficits, for example, by helping parents provide an appropriately responsive and stimulating environment for their child. Concerning family involvement, Guralnick notes that early intervention is now thought to be "most valuable if it is directed primarily toward strengthening natural parent-child relationships, rather than encouraging parents to assume therapeutic or educational roles."[cviii]

Guralnick notes that early intervention is now thought to be "most valuable if it is directed primarily toward strengthening natural parent-child relationships, rather than encouraging parents to assume therapeutic or educational roles."

Outcome measures that include children's social competence are preferred to those that emphasize cognitive language and motor domains.[cix]

Guralnick reports mixed findings on the effects of family involvement in child outcomes of early intervention programs, but finds strong support for family involvement in recent studies of interventions with children with low birth weight and prematurity and their parents: "Programs designed to improve the quality of parent-child interactions and enhance the competence and problem-solving abilities of families using contemporary developmental models have been successful in preventing the usual decline in assessed cognitive development that typically occurs over time for this group."[cx] However, many studies have observed that children with more severe disabilities are less responsive to intervention. Guralnick recommends greater attention to defining family involvement, more sophisticated longitudinal research designs, and greater specificity in the design and analysis of efficacy research.[cxi] Further, he notes that most families included in studies of the outcomes of family involvement in early education were not from seriously disadvantaged families. He sees a need for well-designed studies addressing family involvement with families that are stressed by financial difficulties, lack of social support, or limited education.[cxii] This assertion has implications for the field of early childhood mental health, where family-centered approaches are at an earlier stage of development and systematic program evaluation has been lacking.

A major policy issue yet to be determined is the relative importance of child versus family outcomes in early childhood mental health. With regard to early intervention, Bailey and associates propose a set of questions to focus the evaluation on the processes and outcomes of intervention on the family (see box on the following page).[cxiii] These questions could easily be reformatted to gain families' input on early childhood mental health programs.

EIGHT QUESTIONS FOR ASSESSING FAMILY OUTCOMES

- Does the family see early intervention as appropriate in making a difference in their child's life?
- Does the family see early intervention as appropriate in making a difference in their family's life?
- Does the family have a positive view of professionals and the special services system?
- Did early intervention enable the family to help their child grow, learn, and develop?
- Did early intervention enhance the family's perceived ability to work with professionals and advocate for services?
- Did early intervention assist the family in building a strong support system?
- Did early intervention help enhance an optimistic view of the future?
- Did early intervention enhance the family's perceived quality of life?

Excerpted from Bailey, McWilliam, Darkes, Hebbeler, Simeonnson, Spiker, & Wagner (1998).

Promising Practices in Early Childhood Mental Health Services: Intervention Level

Traditional approaches to early childhood mental health services focused on treating the child's condition through direct intervention by a therapist, often a psychiatrist. In one frequently used approach, the therapist used play therapy or sand therapy, while another professional (often a clinical social worker) offered support and guidance to the mother (only). Often little or no attention was given to family or community context or to culture or socioeconomic status. Individual therapies are now often augmented by approaches influenced by Early Intervention that address the child in his or her family and community context and that aim at increasing children's social competence through the integration of educational, psychological, environmental, sociological, economic, and familial factors.[cxiv] In these ecologically oriented approaches, interventions also take place in the child's and family's natural environment, such as the family home or day care setting.

New conceptual frameworks in the field of early childhood mental health have led to a shift from treating the child alone to working with the child in the larger context of family and social and cultural factors. These frameworks, which are based on ecological theory, view the child and family in dynamic interaction with the social and cultural environment. Kaufmann and Wischman point to the importance of viewing young children in the contexts of their relationships in the wider community:

> Perhaps most importantly, communities interested in promoting the emotional and behavioral well-being of young children and their families must first recognize children as significant members of their communities. Children belong to a variety of communities, such as schools, clubs, peer groups, and the neighborhoods in which they live. Often, very young children are in group child care, informal play groups and recreational programs. However, it is rare for adults to see the child as an integral and integrated part of the community. Even families of very young children are often overlooked while communities attend to the greater political power of their "working residents."[cxv]

Beckman, Robinson, Rosenberg, and Filer have examined the evolution of professional views of families and the roles of professionals and family members in early intervention. Their findings have relevance for early childhood mental health. New approaches to intervention are based on theoretical models that have been used as frameworks for understanding families: family systems theory, stress and coping theory, the family life cycle model, and transactional models. These authors point to the importance of considering culture and resources and present a conceptual model developed by Mahoney, O'Sullivan, and Dennebaum. In their model, the outcome is the developmental competence of the child; parent and family outcomes are considered important because of their role in mediating child outcomes.[cxvi]

To empower families so that they can better care for and cope with a child who has special needs, service providers should accept and support the family as a unit.[cxvii] Cornwell and Korteland propose supporting families of young children with disabilities to achieve their own goals and enabling family members to have positive interactions that promote shared feelings of competence and success. They recommend a family-professional partnership model to facilitate responsive approaches to supporting families, which could apply to early childhood mental health as well as to early intervention (see box). They also recommend adhering to Zuckerman's attribution theory, which predicts that if one makes an external attribution for the onset of problems, and also takes responsibility to solve them, the results will be an increased sense of empowerment, enhanced well-being, and internalized locus of control.[cxviii]

10 KEY ELEMENTS OF FAMILY-PROFESSIONAL PARTNERSHIPS IN EARLY INTERVENTION

- Partnerships should be based on mutual acceptance, respect, and caring.
- Partners should be able to trust each other.
- Partnerships are reciprocal relationships
- Partnership relationships take time to develop.
- Partners should be open to sharing some of themselves in their relationships.
- Families maintain the final decision-making authority in partnerships.
- Partners should share responsibility for their work together to achieve their goals.
- Partners offer help to families in response to their identified needs and concerns.
- Open and effective communication is needed in partnerships.
- Disagreement and negotiation are allowed in partnerships.

Excerpted from Cornwell, J. R., & Korteland, C. (1997).

Simeonsson and Bailey have identified three main approaches to families in early intervention that have implications for early childhood mental health: (1) training parents to teach their child; (2) providing information and support to parents to reduce parental stress and depression and increase coping skills; and (3) offering individualized interventions to help parents gain the skills to help the family and the child with disabilities adapt and develop, such as the family empowerment model.[cxix] Greater parental involvement is generally believed to have positive consequences for the child.

Family systems theory is a guide for addressing the structure, roles, values, beliefs, stresses, coping strategies, resources, and social supports of each family.[cxx] Research by Dunst has demonstrated that help is most beneficial when it helps families acquire behaviors that allow them to meet their needs and achieve their goals. An empowerment approach views families of young children as competent and capable of identifying and meeting their own needs and participating actively in decision making regarding their children's treatment.[cxxi]

Individualized Family Service Plans should be developed on the basis of the following principles: use a family-centered approach; define family in a way that reflects diversity; respect and accept the racial, ethnic, cultural, and socioeconomic diversity of families; respect families' choice of preferred level of involvement in services; offer family-professional collaboration and partnerships; be flexible, accessible, and responsive; normalize services; and use a team approach to implement the IFSP.[cxxii] Kirk Bishop, Woll, and Arango have developed a set of principles for family-professional collaboration that address the processes of developing partnerships between parents of children with special needs and professionals (see box).[cxxiii]

PRINCIPLES OF FAMILY-PROFESSIONAL COLLABORATION

Family-professional collaboration does the following:

- Promotes a relationship in which family members and professionals work together to ensure the best services for the child and the family.
- Recognizes and respects the knowledge, skills, and experience that families and professionals bring to the relationship.
- Acknowledges that the development of trust is an integral part of a collaborative relationship.
- Facilitates open communication so that families and professionals feel free to express themselves.
- Creates an atmosphere in which the cultural traditions, values, and diversity of families are acknowledged and honored.
- Recognizes that negotiation is essential in a collaborative relationship.
- Brings to the relationship the mutual commitment of families, professionals, and communities to meet the needs of children with special needs and their families.

Kirk Bishop, Wall, & Arango (1993).

There is growing attention in the literature to cultural variations in child-rearing practices and to the need to prepare professionals in child-serving fields to appreciate these differences and support culturally diverse families. It is essential for researchers and practitioners in the field of early childhood mental health to be aware of and attentive to how the development of very young children differs across cultures.[cxxiv] Booth draws attention to the implications of specific parental beliefs: parents' causal attributions about their children's abilities and skills (or lack thereof); parents' beliefs about the nature of their role and the child's role in the developmental process; and the role of stress in relation to parental beliefs.[cxxv] She recommends that staff members discuss with parents the beliefs and values inherent in their program and the ways that these may benefit parents or conflict with parents' beliefs. Such discussions may lead to program modifications. Booth notes that a potential benefit of using parental beliefs as a framework for individualizing intervention is that parents may become more involved in the process if it is presented within their own culture of beliefs.

Training for Practice in Early Childhood Mental Health Services

The success of early childhood mental health programs depends to some extent on the training available to staff. Indeed, the innovations discussed in this section often require staff to relearn, or newly learn, specific practices and service delivery skills. A study of factors that contributed to global program quality in early childhood found higher quality programming to be associated with higher levels of teacher education and higher teacher self-ratings of knowledge and skill.[cxxvi] Related to the importance of training is the value that communities (state and local governments as well as child-serving agencies) place on early childhood mental health services. These values may be reflected in salary levels, educational standards, and resources for training.

A number of authors have drawn attention to the need for enhanced training in early childhood mental health, especially in the area of family-centered and interdisciplinary services.[cxxvii] Knitzer notes that work with young children experiencing mental health challenges and their families requires a mix of skills: "child development knowledge, clinical skills, family systems knowledge, multidisciplinary practice skills, and organizational savvy, to name a few."[cxxviii] She recommends that practice guilds and higher education in each state define and develop systems to teach the skills and knowledge needed. McWilliam, Tocci, and Harbin suggest that innovative approaches to training for family-centered services for young children and their families will help service providers gain the sensitivity they need to perceive parents' unique preferences and reactions.[cxxix] Parents and family members of children with mental, emotional, and behavioral challenges can play significant educational roles in effective training approaches to prepare providers for family-centered practice.[cxxx]

A number of innovative education and training programs for improving the quality of preparation for service providers with young children and their families could be used as models for training for early childhood mental health services. For example, in a survey of interprofessional education for family-centered services, Jivanjee, Moore, Schultze, and Friesen identified two programs specifically focused on training for practice with young children.[cxxxi] The Training Program of the Bureau of Children with Special Needs in Bath, Maine, trains early intervention professionals to provide collaborative, family-centered services to young children with special needs and their families.[cxxxii] This program trains providers in the fields of social work, psychology, education, special education, physical therapy, speech therapy, nursing, occupation therapy, and social administration. Parents are involved in planning and providing the training.

The Early Childhood/Early Education Programs of the University of Vermont provides master's level family-centered interdisciplinary training in Early Education and Special Education.[cxxxiii] In this program, parents and family members are active members of the teaching team and are involved in developing syllabi, coteaching, and supervising practicum experiences. Kirk Bishop, Woll, and Arango have used their principles of family-professional collaboration to guide training for family-professional collaboration for children with special needs and their families. They provide examples of programs that offer valuable ideas for training for early childhood mental health services.[cxxxiv] In short, ongoing and thorough training in a range of skills and competencies will be necessary for early childhood services that are effective and innovative.

Another example of innovative training and support of efforts in the field of early childhood mental health is California's use of Proposition 10 dollars. In 1998, California voters passed Proposition 10, the Children and Families First Act, which imposes an excise tax on the sale of cigarettes. Year 2000 revenues are expected to reach $690 million and will be used to improve early childhood development. In the case of California and these funds, a state commission and individual county commissions oversee expenditures. Counties are apportioned 80 percent of these funds (20 percent goes to the state commission), and county commissions "have wide discretion and can spend the funds on a array of programs and activities, including education, child care, social services, health care, and research."[cxxxv] Local communities have been able to offer increased attention to outreach, early diagnosis, treatment, and evaluation, which will ideally lead to increased access to services.

The text of the Act specifically directs funds to education and training for child care providers and education and training for parents in newborn and infant care and nurturing for optimal early childhood development. The use of Proposition 10 funds in California is particularly innovative and promising for early childhood mental health services because these funds are specifically targeted to support an "integral, comprehensive, and collaborative system of information and services."[cxxxvi] Further, the funds are available for a wide range of services, including prevention, diagnostic screening, and treatment not covered by other programs. (For additional information on Proposition 10 and early childhood issues, see www.cchi.org.)

Promising Practices in Early Childhood Mental Health Services: Values and Principles

This literature review of theoretical frameworks guiding emerging practices, discussions of the policy context, and descriptions of innovative programs and practices builds a foundation for identifying values and principles for early childhood mental health. These values and principles focused our inquiry and guided our questions as we prepared for site visits. Cohen and Kaufman present a set of values inherent in the mental health perspective that reflect our evolving conceptual framework. According to Cohen and Kaufman, the mental health perspective in early childhood is based on the following values:

1. All young children deserve to spend their days in a safe, stable, caring, nurturing environment, which promotes healthy social and emotional growth and resiliency, protects young children from psychological harm, and creates conditions conducive to well-being.
2. To meet the mental health needs of young children, it is critical to consider the quality of the child's many relationships.
3. Families are considered full participants in all aspects of the design, implementation, and evaluation of programs and services for young children.
4. Early childhood mental health services are responsive to the cultural, racial, and ethnic differences of the populations they serve.
5. Practices build upon, promote, and enhance individual, family, and child care staff strengths.[cxxxvii]

A number of authors have developed related principles for early intervention and children's mental health that we have synthesized into a framework for examining promising practices at the Children's Mental Health Initiative sites. The following principles, based on the work of Stroul and Friedman, Woodruff and her associates, and Knitzer,[cxxxviii] present a philosophical and conceptual framework for understanding and developing efforts to promote early childhood mental health.

Early childhood mental health practice should be the following:

- *Family-centered.* Supports and services are designed according to the family's strengths, needs, and preferences. "Family" is defined in the way that the family defines it and reflects diverse and dynamic family membership and patterns.
- *Individualized.* Programs and services respect families' racial, ethnic, cultural, and socioeconomic backgrounds and their values and beliefs. Interventions are tailored to address families' unique needs and strengths.
- *Comprehensive.* Service arrays include a variety of interventions that take into account the developmental, health, and mental health needs of families and the potentials for preventive as well as therapeutic interventions.
- *Community-based.* Community-based interventions are provided in the natural environments of young children and their families and incorporate informal supports that are found in the community.
- *Coordinated/transdisciplinary.* Since no one agency or discipline can meet the diverse, complex, and changing needs of young children with special needs and their families, transdisciplinary collaboration and coordinated services are recommended.
- *Fully inclusive of families in decision making.* Family members are active participants at all levels of making decisions about their children's care and are involved in designing, implementing, and evaluating services. Family-professional partnerships and collaboration are key components of empowerment-oriented interventions.
- *Focused on developmental needs.* Effective programs address the developmental needs of children in all areas of functioning.
- *Built on strengths and resilience.* Interventions are designed to promote resilience in children and build on family strengths by enhancing self-esteem, improving coping strategies, and increasing positive social support.

These principles provide a general framework for thinking about effective interventions in early childhood mental health services. Although the literature offers some examples of specific activities that lead to positive outcomes, a need exists for more specific knowledge about how these principles are translated into concrete actions and ways of relating in the local contexts of service delivery. We provide a synthesis of these principles and their sources in the literature in Appendix C. In the case studies that follow the section on methodology, we present examples of specific strategies that some communities have adopted to implement principles for promising practices in early childhood mental health services.

CHAPTER 2: DATA COLLECTION AND INQUIRY

This section of the monograph provides a context for the sites we visited and describes our process of collecting data. The promising practices featured in the next section are practices, strategies, and approaches that support work with very young children and their families. Much of the information draws on systems of care funded by the Center for Mental Health Services through its Comprehensive Community Mental Health Services for Children and Their Families Program. We found a range of promising practices in each site we visited; throughout the monograph, we present the sites in alphabetical order.

BACKGROUND AND CONTEXT

We began our work with two definitions that underlie all the monographs in this series. Our target population was "children and adolescents with a serious mental disturbance and their families." In addition, the inability to "perform in the family, school, and/or community is the basic factor which determines the need for services."[xxxix] Through site visits and telephone interviews, we quickly learned that work with very young children rarely mirrors the delivery of services to children over 5 and their families.

Children who need support at a very young age may not fit easily or quickly into a specific diagnosis. At the same time, participants working in systems of care serving very young children and their families repeatedly emphasized the value of working with children at a very young age.

> We quickly learned that work with very young children rarely mirrors the delivery of services to children over 5 and their families.

Two of the five sites we visited (Kansas and Illinois) received supplemental grants (through the Starting Early, Starting Smart grant program) specifically directed at caretakers of children ages 0 to 7 who have a diagnosis of chronic mental illness or substance abuse. Additionally, the Positive Education Program in Cleveland, Ohio, is not supported by Community Mental Health Services for Children and Their Families Program funds; staff at this program have been delivering services to very young children and their families for more than 20 years.

> Intervention with a very young child often was offered in connection with support to family members, in the form of wraparound meetings, parenting classes, and observation of parent-child interactions.

Site-specific evaluation is an ongoing and required component of system of care development for the Community Mental Health Services for Children and Their Families Program grant communities. This evaluation, conducted by MACRO International, provides insight into the 0 to 5 population receiving

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services in connection with grant monies. Data from the 28 sites funded in the first five years of the grant program indicate that 7.7 percent of the children served were 5 or younger. Of these children, most were referred through a school, a mental health agency, a parent, or a social service agency. Nearly all of the Community Mental Health Services for Children and Their Families Program grant communities provide some services to very young children and their families. At the same time, the field of early childhood mental health is developing, not only in the Community Mental Health Services for Children and Their Families Program grant communities, but also in the children's mental health arena more generally. Research addressing the utility of diagnostic categories that are specifically for children 0 to 5 is ongoing, and therapists who have a specialty in child development (particularly in the 0 to 5 age range) are rarely available, particularly in rural areas.

Participants in systems of care view work with very young children as a valuable and necessary component of mental health services.

We hope that this monograph sheds light on the value of early childhood mental health services and on the process of designing and delivering these services. By reviewing promising practices in a few specific Community Mental Health Services for Children and Their Families Program grant communities, as well as at the Positive Education Program in Cleveland, Ohio, we are able to offer several strategies and approaches to early childhood mental health services. We also hope that our examination of early childhood mental health services fosters increased discussion and information sharing.

DATA COLLECTION

A literature review, telephone interviews, and site visits were the three primary mechanisms we used to gather information on early childhood mental health services. The literature review focused on articles on early childhood mental health, early intervention, and developments in the general area of early childhood services. As we reviewed the literature, we were particularly interested in how practices and concepts addressed in the literature reflect the principles important to the Community Mental Health Services for Children and Their Families Program communities. For example, such issues as family participation, individualized services, and a wraparound approach were important to us as we looked at the literature. Additionally, the literature review was influenced by our interviews with people with experience in the early childhood field.

We conducted interviews with experts in the early childhood field, as well as with people in communities offering creative and innovative services to young children and their families. These interviews helped us think about what communities to visit and what to look for in our site visits. Combined with our literature review, these initial interviews were particularly relevant as we conceptualized mental health services to very young children and their families; identified the links between the types of early childhood providers; observed recurrent themes regarding what kinds of services are useful for very young children and their families; and considered the kinds of topics to discuss when we visited the five communities.

Once we had completed an initial literature review and several key informant interviews, we sent a letter to family coordinators and directors at all of the Community Mental Health Services for Children and Their Families Program grant communities. This letter explained the topic area for our monograph and invited responses from any grant communities who were providing services to very young children and their families. Representatives from several grant communities responded, and we chose four communities on the basis of their array of early childhood services and geographical and cultural balance. Throughout our initial work on the monograph, we heard frequent references to the Positive Education Program in Cleveland, Ohio. We chose to visit this program, which does not receive funding through the Community Mental Health Services for Children and Their Families Program, primarily because of its 20-year history of offering a comprehensive array of early childhood services. Telephone interviews were conducted with several other grant communities.

We visited the following sites:

- Children's Upstream Services Project serving children and families in Vermont
- Community Wraparound Initiative serving Lyons, Riverside, and Proviso Townships in Illinois
- KanFocus and Project Before in southeastern Kansas
- Kmihqitahasultipon Program serving the Passamaquoddy tribe in Maine
- Positive Education Program in Cleveland, Ohio

Telephone and site visit interviews were qualitative and open-ended. We spoke with program directors, therapists, child development specialists, family advocates, and families receiving services. In some cases, we had the benefit of attending meetings, such as those of wraparound teams. Broadly, we focused on the overall structure and context of services, the array of services, family participation, and challenges and lessons learned. We present the information we gathered from site visits, interviews, and the literature review in the following section. The protocol we used for these visits can be found in Appendix B.

All three components of our data gathering are integral to the information contained in the monograph. Even though we began with a literature review, then moved to interviewing specialists in the field of early childhood, and then completed the site visits, each aspect of gathering data helped us think in different ways about the overall process. For example, our interviews with specialists in the field encouraged us to return to the literature review and look further for certain areas of service. Even as we completed and implemented the site-visit protocol, our visits to communities serving very young children and their families helped us see areas in the literature that might need more attention and additional research.

In a similar manner, the links between the philosophical concepts of early childhood mental health (discussed at length in the literature and in some of our interviews with early childhood mental health specialists) and the practice concepts of early childhood mental health interacted in complex ways throughout the study. For example, we approached the topic of early childhood mental health with some clear thoughts and preferences about mental health services to very young children and their families. We were very attentive to the Child and Adolescent Service System Principles, as well as to the importance of family participation at all levels of the system of care. The values articulated in these principles certainly influenced how we read the literature and how we conceptualized the site-visit protocol.

In many cases, we found strong links between the research in the literature and the practice in the sites we visited. Researchers in the fields of early childhood mental health and early intervention have come to specific conclusions in some areas. These researchers point out that we have important knowledge about what early childhood services should include, how diagnostic categories work with very young children (and some of the accompanying challenges), what relevance risk and protective factors have to early childhood mental health services, and what successful programs look like. The findings in the literature offered us ways to think about services and programs as we visited sites.

As we completed the monograph, we also noticed areas that will need attention in the immediate future. How policies directly affect families (for example, Temporary Aid for Needy Families, managed care, the Adoption and Safe Families Act, or the Child Health Act) is a critical issue. Funding is also important for early childhood mental health services; people we interviewed during our site visits focused more on actual services, and on how a community can work across systems to provide those services, than on specific funding sources. This focus may have been a result of our questions, of the particular directions and challenges present within each community, or of both.

Finally, even as we carried the findings from the literature with us, we looked for new and innovative practices in each site. What were staff in these communities doing for very young children and their families that was different from what we found in the literature? How did a community deal with a particular challenge, for example, a very rural population (Kansas) or the lack of certified providers within a community (Maine)? In featuring promising practices, we wanted to discover how communities were responding to well-known challenges to service delivery—for example, how to encourage and sustain family participation at all levels of a system of care or how to collaborate among several early childhood providers so that services for individual families are not fragmented—in ways that offered new insights into early childhood mental health services within that particular community and context.

CHAPTER 3: SITE VISITS

We visited five agencies offering mental health services to very young children and their families. Four of the communities are (or were) funded by the Center for Mental Health Services as part of the Community Mental Health Services for Children and Their Families Program (see box on page 41).

- Children's Upstream Services Project in Vermont
- Community Wraparound Initiative in Lyons, Riverside, and Proviso Townships, Illinois
- KanFocus and Project Before in southeastern Kansas
- Kmiqhitahasultipon Program in Indian Township, Maine
- Positive Education Program in Cleveland, Ohio

These programs represent rural and urban populations and serve children and families from a mix of socioeconomic and racial/ethnic backgrounds (including primarily, but not exclusively, African American, American Indian, and European American). We did not visit communities that work with large Asian American or Spanish-speaking populations, primarily because grant communities serving these populations did not have extensive services for very young children at the time of our research.

We examined the operating philosophy of early childhood mental health services, the services offered, the structure and financing of each program, and promising practices at each site. This section presents a clear overview of how early childhood services are offered in five communities and discusses innovative strategies and approaches that staff use to achieve promising practices in each agency. In each agency, we found unique promising practices that can offer insights to those who have a stake in the design and delivery of mental health services for very young children and their families.

CHILDREN'S UPSTREAM SERVICES PROJECT, VERMONT

Vermont has long been a leader in the development of services for children with serious emotional disorders. Building on an earlier Child and Adolescent Service System Project (CASSP) and a Robert Wood Johnson grant (which introduced interagency teams and wraparound services to Vermont), the state's first Child Mental Health Services Initiative grant, ACCESS Vermont, brought children's crisis outreach services throughout the state. The Children's Upstream Services (CUPS) project is the second Child Mental Health Services Initiative grant in Vermont and the only one with a specific focus on children under 6.

Vermont was one of the first states to develop regional interagency teams and now has active Community Partnerships in each of its 12 regions. These Partnerships are instrumental in sustaining the ACCESS Vermont services, are responsible for handling Success by Six funds (a state general fund–

supported primary and secondary prevention project for children 0 to 6 and their families), and help with regional planning for CUPS services. The state has a well-organized, modestly funded system of services for young children (including those with disabilities) through a variety of state and federal projects. Because of this well-developed planning infrastructure, and the investment that Vermont has made in prior years in its very young children and families, the Children's Upstream Services grant links two functioning systems of care.

Two promising practices in Vermont include integrating mental health services into existing child-serving agencies and expanding the existing mental health services for very young children and their families. Consistent with the early childhood principles we discussed earlier, Vermont has worked hard at supporting a community-based and transagency array of services for very young children and their families. The state has intentionally avoided setting up new structures and systems, choosing instead to expand existing programs that support very young children and their families. Further, staff in Vermont have generously offered training, consultation, and technical assistance to agencies that serve very young children, which has resulted in coordinated and comprehensive services. The extensive array of services is another clear promising practice that links to the principles discussed earlier.

Philosophy

In Vermont, the Children's Upstream Services Project uses a philosophy of "taking mental health to early childhood" in the development of services for very young children. The project has built its collaborative activities specifically on an existing structure at both state and regional levels. Vermont has a long history of regional and local governance and consequently had a framework in place to promote interagency collaboration and community involvement for very young children.

The CUPS project has the following primary objectives:

- To work with the 12 regional Community Partnerships to develop and implement strategic plans that will link the existing system of care for children with serious emotional disorders and their families with the existing early childhood service system
- To expand key services needed to improve the behavioral health of very young children
- To develop and deliver comprehensive training and technical assistance to ensure cross training between the two systems of care

These primary objectives reflect the main philosophical approaches of the project. First, staff at the CUPS project build on early childhood services in the community instead of creating an additional service system. They work with existing child-serving agencies that might benefit from mental health perspectives and resources. Thus, building and maintaining relationships with other child-serving agencies is crucial; once a relationship is in place, staff are better able to collaborate around delivering services to meet the concrete mental health needs of families. Finally, Vermont has learned that extensive training and technical assistance, on a statewide basis, is crucial to successful services for children of any age. Thus, in the case of early childhood, training and technical assistance must be available to mental health agencies and other agencies with which CUPS works collaboratively.

OVERVIEW OF THE SITES VISITED

CHILDREN'S UPSTREAM SERVICES PROJECT, VERMONT

Service area: Entire state, divided into 12 regions
Organizational structure: Community collaboratives in each of 12 regions plan early childhood mental health services.
Center for Mental Health Services funding history: Project Access received funds from 1993 to 1998; Children's Upstream Services Project began receiving funds in 1998.

COMMUNITY WRAPAROUND INITIATIVE, ILLINOIS

Service area: Lyons, Riverside, and Proviso Townships
Organizational structure: Services are coordinated through local area networks created by the state; the Community Wraparound Initiative was established as an administrative structure by the state mental health department and an InterLan council made up of the local area networks from the three townships.
Center for Mental Health Services funding history: The program received funds from 1994 to 1999 and received a three-year supplemental grant directed at caretakers of children 0 to 7.

KANFOCUS AND PROJECT BEFORE, SOUTHEASTERN KANSAS

Service area: A 13-county area in rural southeastern Kansas
Organizational structure: Five mental health centers serve 13 counties; regional staffs are housed and given financial accounting support by the Labette Center for Mental Health in Parsons.
Center for Mental Health Services funding history: The program received funds from 1994 to 1999; many components of KanFocus are currently funded by the state. The program received a three-year supplemental grant directed at caretakers of children 0 to 7.

THE KMIQHITAHASULTIPON PROGRAM, INDIAN TOWNSHIP, MAINE

Service area: Passamaquoddy Tribe of 900 community members
Organizational structure: The program works within Indian Township Health Center as the primary provider of mental health services for children and their families.
Center for Mental Health Services funding history: Program was initially funded by Wings of Maine and began receiving funds independently of Wings of Maine in 1997.

POSITIVE EDUCATION PROGRAM, CLEVELAND, OHIO

Service area: Cuyahoga County, which includes Cleveland and surrounding areas
Organizational structure: Early Intervention Services make up one arm of the Positive Education Program, a non-profit agency that has been meeting the mental health and educational needs of children for 20 years.
Funding history: The program is funded primarily by the Cuyahoga County Department of Mental Health and the Ohio Department of Education and excess tuition costs paid by local school districts, as well as a recently implemented, county-level Early Childhood Initiative. It does not (and has not) received funds from the Center for Mental Health Services.

Services

The Children's Upstream Services Project delivers a range of services to very young children and their families that is uniquely configured in each region. These services include home visits to new parents, playgroups, and therapeutic outreach services. In addition to discussing these services, this section addresses family participation in the design and delivery of early childhood services in Vermont and the services that CUPS provides to child care centers and homes.

As a way to initiate the activities of the CUPS grant and involve the whole state, the Community Partnerships were invited to develop proposals for funding under the grant. To assist the Partnerships in this process, an Outreach Team was formed from members of the State Team for Children and Families and its Early Childhood Steering Committee. This team traveled to each of the 12 regions to provide technical assistance and to address how Community Partnerships might best use the CUPS project funds to "increase the behavioral health treatment available for families with young children aged 0-6 and the behavioral health consultation available for the early care and education system" (Letter to the Community Partnership Regional Contacts, January 23, 1998). Small grants of $6,000 for each region were available to support the planning process. All regions submitted strategic plans for funding under the CUPS project; the plans were approved by the State Outreach Team and funded. This early attention to planning and designing services afforded communities a unique opportunity to carefully consider what kinds of services to offer and how to offer them.

The services supported by the Children's Upstream Services Project are configured differently in each region. For example, in Washington County, CUPS supplements several already successful services:

- The Welcome Baby project: A free one-time visit to every family with a newborn or newly adopted baby
- Success by Six home visits: Family support and information on a broad array of topics related to child development and behavior
- Therapeutic outreach services: Individual psychotherapy, play therapy, family and couples therapy, and case management provided by mental health staffs
- Teen parent services: Weekly peer group support, group outings, and individual home visits
- Playgroups: Offered free of charge to all parents and sponsored collaboratively with the local school districts
- Community development: Planning and coordination of family activities in each community sponsored by six local teams

The Children's Upstream Services Project augments this array of services to increase the number of Outreach Therapists available; to offer a variety of training, workshops, and groups for parents of young children with emotional and behavioral challenges and for service providers in the county; and to provide consultation for child care providers and preschools. This regional CUPS project is staffed by two social workers who are assisted by parent aides.

Through therapeutic outreach, therapists meet with families in their homes on a weekly basis to provide therapeutic intervention to young children experiencing emotional and behavioral challenges. Although the intervention focuses on the child, the caregiver receives support and information. For families with more intense needs, case management and other social services are offered.

One important aspect of services from the perspective of mental health case managers in Vermont is their ability to continue working with families over an extended period. In many cases, this work continues beyond what many of the other service providers from early childhood projects are able to provide, especially if the child is diagnosed with a serious emotional disorder and can receive services through Medicaid.

Although early childhood providers might view their work with families as limited to a short period during which the family adjusts to the demands of a child's disability and a plan for services is put in place, in some cases, services that last longer are more relevant and appropriate. Some providers do not understand the complexity of behavioral or emotional disorders; the nature of behavior may change frequently, requiring a revision to a wraparound plan and a response to a crisis. In this sense, the Children's Upstream Services Project in Vermont is filling an important need for services that support families for as long as the services are useful or at least for as much of that time as possible.

ONE PARENT'S USE OF *SOCIAL STORIES*

A mother in Vermont described the process she had to go through to create ways of managing the environment for her 3-year-old child whose emotional disorder makes it difficult for her to wear clothes or have anything touch her skin. Because her child has so much trouble entering new or unfamiliar situations, she had developed *social stories* that she writes down for her daughter. Each story describes in detail the upcoming situation, what it will be like, and what may happen. She reads these stories over and over to her daughter before each transition. Her 8-year-old son also reads these stories to his sister, creating a positive activity for the two of them to do together.

Family Advocacy Organizations

In Vermont, we were fortunate to speak with three advocacy organizations: the Vermont Federation of Families, Advocacy Resources and Community (VARC), and the Vermont Parent Information Center. Each organization has a slightly different constituency group. The Vermont Parent Information Center works with families and children with special needs and learning and behavioral difficulties statewide and provides information to professionals and service providers. The center serves children from birth to 22 and all disabilities. VARC is an association that offers information, support, and services to individuals of all ages with developmental disabilities and their families. The Vermont Federation of Families for Children's Mental Health provides support, information, and advocacy to families who care for children birth to 22 with serious emotional disorders.

All three of these family advocacy organizations are involved with the Children's Upstream Services Project grant. They are members (along with many others) of the Family Training Consortium, which is an outgrowth of the Learning Team (discussed in the Structure and Finance section), and the CUPS training and technical assistance committee. The purpose of the Family Training Consortium is twofold: (1) to build a non-categorical, regional capacity for support, advocacy, and training for families and (2) through a Family Outreach Team, to consult with the 12 regional Partnerships and other groups about family involvement in regional governance and human service decision making (including CUPS). A budget is available to help the Family Training Consortium accomplish these goals.

Support for Child Care Providers

The Children's Upstream Services Project also encourages local programs to consult with child care providers about difficult behaviors that children exhibit while in day care. For example, the Chittenton County Community Partnership submitted a regional plan that includes a full-time staff person to advise local child care providers. In addition, three full-time early childhood mental health consultants are available to provide case management and consultation to individual families through the Baird Center for Children and Families, located in Burlington.

These consultants offer training, technical assistance, and consultation to child care providers and to parents who have a child experiencing emotional and behavioral difficulties. This service focuses on increasing the capacity of caregivers, teachers, and parents to manage challenging behaviors by developing strategies collaboratively. Services are usually offered either in the child's home or at the child care setting. Often, services include training for the child care providers and parents in a number of areas, such as behavior management, anger management, positive and effective discipline, stress reduction and stress management, safe restraints, and other specific skills. Referrals generally come from child care providers and preschool staff or from other mental health providers within the Baird Center.

The CUPS Project in Washington County also provides training, consultation, and workshops for early childhood caregivers and family members. Two staff members are available to meet with child care and playgroup providers in the county to discuss their concerns about a child with an emotional or behavioral challenge. This consultation involves observing the child and holding a follow-up meeting at which the care provider and the parents of the child receive feedback.

Structure and Financing

Vermont has a long history of regional and local governance. Consequently, prior to receiving grant funds, the state had a framework in place to promote interagency collaboration and community involvement for young children. Two structures, the State Team for Children and Families and the Learning Team, are particularly germane to early childhood mental health services.

The State Team for Children and Families was created in 1994 to achieve greater collaboration at the state level and to foster strong partnerships with community and regional collaborative groups that are devoted to improving the well-being of children and their families. The State Team comprises division directors of state agencies that serve children and their families, state-level coordinators of interagency teams, and directors of several family services and family advocacy organizations. The Early Childhood Steering committee is one of the interagency teams reporting to the State Team for Children and Families.

The Early Childhood Steering Committee grew out of efforts to assist state agencies in working with parents, providers, educators, and others to develop for at-risk children a comprehensive and effective system of services using the principles of prevention and early intervention. The primary resources for carrying out this mission have been grants from Success by Six, a state-funded project to provide primary prevention and early intervention services to all young children in Vermont. The Early Childhood Steering Committee now oversees the Success by Six grants, with help from the Community Partnerships and their new Early Childhood Councils. At the local level, the 12 regional Community Partnerships are responsible for planning and coordinating the activities of a variety of initiatives, including Success by Six, ACCESS Vermont, and, most recently, the Children's Upstream Services Project.

Under the Children's Upstream Services Project, Vermont has also organized a statewide Learning Team. The idea for this team came out of a retreat held shortly after the grant was funded. A wide range of individuals was brought together to talk about the kinds of training and technical assistance support that the regions would need to implement the goals of the grant.

The Learning Team meets monthly and is very active. It brings together state-level staff from mental health and early childhood, individuals from various higher education institutions, family members, and representatives of family organizations. The Learning Team assessed the training and technical assistance needs of the regions first on the basis of their written service plans and second on the basis of a written needs assessment that was sent to each region. This assessment led to a series of workshops about "Building Skills to Support the Social and Emotional Well-Being of Young Children and Their Families." One activity of the Learning Team is to coordinate training activities across the state to avoid duplication and to better target identified needs. The Health and Education Departments have contributed funds for this training effort, along with CUPS funds from Mental Health.

A subcommittee of the Learning Team is working on core competencies. The team decided to identify the core competencies needed for "Promoting the Emotional and Social Development of Young Children." (A draft version is now available.) Next, the subcommittee plans to delineate the competencies needed to work with children with mental health problems.

Prior to CUPS, Vermont amended its Medicaid plan to allow parent-child center staff who are certified Early Interventionists to bill Medicaid for targeted case management for developmental therapy for 0 to 3 year olds who lack expected normal physiological development or who show a developmental, speech, or language disorder. Community Mental Health Center staff can also bill Medicaid for eligible children with a mental health diagnosis. Targeted case management can be billed for children with serious emotional disturbances, which allows collateral contact with their families. Thus, Vermont's early intervention and support services can be provided for the very young children of transition-aged youth with serious emotional disorders. This allows case managers to target and serve a group of high-risk young children without placing a diagnostic label on them. Both the parent and the young child are eligible for services because of the parent's disability.[cxl] Young children are also eligible for services because of their own disability.

According to staff at the sites we visited, the most difficult services to find funding for are the indirect services, such as those that are provided to the staff of a preschool project or to a whole classroom of children. These services cannot be reimbursed through the usual mechanisms because no one child is identified as receiving services. As one provider in Vermont noted, "We know how to find funding for services to a child with a diagnosis. These other (indirect) services are more of a problem." Some creative ideas that providers are exploring include looking at Title IV-E of the Social Security Act as a way to fund training for service providers and child care staff and using Medicaid administrative funds for consultation.

Promising Practices

Building on a long and strong statewide history of mental health services to children and their families, the Children's Upstream Services Project has supported a structure for services, as well as for technical assistance and training, that effectively meets the needs of very young children and their families. Unique aspects of services in Vermont include a model that integrates mental health services into existing child-serving agencies and training to support this model.

Community-Based and Coordinated/Transdisciplinary Services

Stakeholders in children's mental health systems of care in Vermont have intentionally not built new systems and structures to serve very young children and their families. Instead, they have taken stock of what services exist and how different child-serving agencies are working with the mental health challenges that very young children face. They have also built and maintained strong relationships with a variety of child-serving agencies that work with very young children and have collaborated with the staff at these agencies to improve the range and depth of mental health services within those agencies. Central to this approach have been training, consultation, and technical assistance in the area of mental health support to very young children and their families and ways to offer these services to specific agencies. Staff have also been innovative in forming statewide partnerships so that people who have a stake in serving very young children and their families in Vermont have a vested interest in working together to improve services.

Individualized and Comprehensive Services

Through CUPS, the number of mental health workers for serving very young children has been expanded statewide. These workers have supported other child-serving agencies to further (and sometimes newly) develop mental health services to include attention to very specific services in the range of early childhood settings (for example, how child care staff might work with a child facing mental health challenges). In addition, the State Team for Children and Families was developed in 1994 to increase state-level collaboration and to foster community partnerships. The Outreach Team helped develop strategic plans for each region and for services available to all children and their families. This attention to collaboration in Vermont has led to a wide variety of individualized services.

COMMUNITY WRAPAROUND INITIATIVE, ILLINOIS

In Illinois, services for very young children and their families are part of the overall range of services coordinated through state-created Local Area Networks, which include representatives from state and local mental health and educational organizations, child welfare, and the local family organization. Services for very young children and their families are provided by the Community Wraparound Initiative in Lyons, Riverside, and Proviso Townships. The decision-making body for the Initiative is one of several Local Area Networks. This coordination among several child-serving agencies is especially useful in delivering services to very young children and their families.

The Community Wraparound Initiative began receiving funds in late 1994 and received an Early Intervention Supplemental Grant in 1996, directed at caretakers of children 0 to 7. Integrated Family Services, which is primarily funded by this supplemental grant, is one of the two primary programs working under the Local Area Networks and is the program serving very young children and their families. The supplemental grant is specifically directed at caretakers of children 0 to 7 who have a diagnosis of chronic mental illness or substance abuse (or are in the process of obtaining such a diagnosis). To meet the requirements for services, the caretaker, defined as any adult who is responsible for the daily care of the child or children, must have a mental health diagnosis (which might include schizophrenia, bipolar disorder, major depression, or obsessive-compulsive disorder) or must meet certain substance-abuse criteria (active substance abuse; less than 12 months of sobriety; or more than 12 months of sobriety, but no apparent support system for recovery).

The Integrated Family Services Program works closely with Head Start to identify families at risk and to offer a broad base of support for very young children with emotional and behavioral challenges and their families. Children who are referred for services can receive assessment and diagnosis, consultation with a child development specialist, therapy, and other supports; these services are home-based or office-based. Wraparound facilitators and family resource developers work out of three Community Wraparound Initiative offices. The primary roles of wraparound facilitators are to coordinate team meetings and to link services and supports with children and families. Family resource developers are paid staff whose children have received or are receiving services.

Promising practices in Illinois include a strong commitment to wraparound services, to family participation in the design and delivery of services, and to links with other child-serving agencies. The commitment to wraparound services often requires unscheduled meetings with the whole team, sometimes in the evening or off site, and demands an openness and a willingness to work through conflict that are rare in children's mental health services. In our site visit, we sat in on a team meeting; disagreement was faced head on, and staff members held the family member accountable to her goals in a supportive manner.

Family resource developers are an integral part of the staff in Illinois. They fill part-time and full-time paid positions and are all family members. They are central to the delivery of services to children and their families and have an active role in the larger community, developing strong working relationships and connections with other agencies that serve very young children and their families.

Philosophy

The four main philosophical commitments in Illinois are (1) creating as broad a support network as possible for children and their families; (2) implementing wraparound services at all levels and supporting staff for that implementation; (3) assigning a significant role to families whose children have received or are receiving services in the design and delivery of services; and (4) promoting strong links with the community. At an obvious level, these philosophical guidelines parallel the early childhood principles of a broad array of services, family participation, individualized services, and coordinated services. All of these commitments are reflected in the design and delivery of services.

The Community Wraparound Initiative often works with children and families that other agencies have turned away. In some cases, children receiving services live with a caregiver who is actively abusing drugs or alcohol. Children and parents come into services experiencing a broad range of needs. Therefore, staff at the Initiative include service providers who focus on substance abuse in the broad range of supports for the parents.

Staff have seen parents or caregivers make dramatic changes, such as entering recovery and returning to work. These same caregivers have also significantly improved their parenting skills. In short, staff at the Community Wraparound Initiative have learned the benefit of working with the entire range of strengths and needs with which families enter services and of drawing on informal and formal supports to offer the parents what they need to be better caretakers of their children.

To offer the individualized services necessary, staff at the Community Wraparound Initiative have made a commitment to wraparound services for all families, even when this is difficult and challenging. The result has been a significant change in service design and delivery. When staff began offering services, intensive training related to the wraparound approach was available. Administrative staff brought in outside trainers and consultants; formal learning groups were created to offer a way to provide ongoing support for a wraparound approach (for more discussion of learning groups, see the "Structure and Financing" section). As one wraparound team leader expressed, wraparound brings "everyone into the same room and the closeness can be difficult," particularly when professional training has not included attention to the differences between wraparound and traditional case management.

One key philosophical component of the Community Wraparound Initiative is the central role of families. Family members whose children are receiving or have received services are hired as paid staff members, called family resource developers, who have a significant role in the design and delivery of services. These staff members serve on all wraparound teams and are often the primary contact the family has with services. They often work in the neighborhoods in which they live, and each has an area of expertise within the community. They are able to identify the natural supports in the community and act as advocates in relation to those supports. Family resource developers often run into families who are receiving services in the grocery store, at church, or simply in the neighborhood, which allows them to see the families in their natural environments.

Because family resource developers are particularly aware of the day-to-day situations of the families with whom they work, they are well situated to collaborate with the wraparound team on service coordination and respite services. Parents are often better able to talk to other parents about what they need, and family resource developers are able to present child development principles to new parents. Family resource developers have a proactive role in the community and can educate staff who work with very young children in other settings about mental health issues.

Finally, staff at the Community Wraparound Initiative have learned the value of community links when offering services. Particularly when dealing with parents of very young children (in part because of the large early childhood community), staff need strong working relationships with other agencies that serve these children. As noted above, the family resource developers, as well as other Community Wraparound Initiative staff, have well-established working relationships with the early childhood community. One full-time and two part-time family resource developers serve as links between family members, community resources, and the mental health staff, and they play a vital role in the wraparound process.

Services

Services at the Community Wraparound Initiative for very young children and their families include play therapy, respite care, flexible funds, substance abuse treatment, tutoring, day camp, video assessment and review, and work with the family focused on achieving on their goals. In particular, the video assessment and careful and ongoing work with families and their goals present unique perspectives into services for very young children and their families. The Community Wraparound Initiative employs a child developmental specialist, who also offers critical input (see "Structure and Financing" section for more information on the child developmental specialist). A central component of services at the Community Wraparound Initiative is the wraparound meeting with the parents and the child(ren). In the first few meetings, the family and team write a vision statement that details specific goals and includes particular objectives the parents would like to reach with their child. The entire team discusses how the family came to its present situation and the experiences the family went through prior to receiving services. In this way, the team builds a sense of perspective with the family. Everyone involved acknowledges the skills the family has and then works on ways for the family to build on these skills to work with the strengths and needs of its child(ren). Articulating a vision statement, and remaining concrete about how certain steps will be accomplished, also offers ways for the parents to take an active role in improving the lives of their family members and gives the entire team a sense of accountability.

In actual practice, committing to a long-term process that acknowledges the role of the families' past in working toward future goals is not easy. It requires a high degree of honesty on the part of the families, a thorough commitment to strengths-needs–based services on the part of all staff, and a willingness to stick to a process on the part of the entire team. At the same time, this process affords the possibility for services to be meaningful and wide reaching. When we sat in on a wraparound meeting, the team, including the mother receiving services, discussed her housing situation as well as child care possibilities so that she could work. Members of the wraparound team referred often to the goals and objectives the mother had laid out for her family and to the concrete ways in which these goals could be reached. The attention of the team to the whole family acknowledged the important connection between parents' well-being and the health of their children. When parents' strengths are respected and their needs are met, they are consistently better caregivers to their children and are more attentive to their children's development.

In Illinois, the child development specialist is trained in using videotaping for assessment. About one-third of the very young children receiving services participate in the videotaping process, which involves four steps: a snack or drink given by the parent to the child; free play; structured play (in which child is asked to do certain tasks); and separation and return.

Following the videotaping, the child development specialist and parent review the video, and the child development specialist interviews the parent and assesses the child. Reviewing the videotape presents a concrete opportunity for the child development specialist to comment on what the parent is doing well as he or she interacts with the child. Following the assessment, the child development specialist and the parent work on specifying concrete goals for the parent-child relationship and for the child's behavior. At the time of our visit to the Community Wraparound Initiative, the child developmental specialist was training other staff to use the video assessment with very young children and their parents.

Structure and Financing

Services to very young children in Lyons, Riverside, and Proviso Townships are largely supported by an Early Intervention supplemental grant. Staff who support Integrated Family Services include an early childhood services administrator, case managers, counselors, family resource developers, the child developmental specialist, and a certified alcohol and drug counselor. In particular, wraparound teams always include a wraparound facilitator, a child developmental specialist, a family resource developer, and the parent(s) and child(ren); they often include a certified alcohol and drug specialist. The child developmental specialist works on a consultation basis a few days a week and is trained in the developmental needs of very young children. In this setting, the child development specialist is likely to focus on the relationship between parent and child.

Family resource developers are a central part of Integrated Family Services. Usually, three or four family resource developers work with between 12 and 18 families each. Family resource developers are a particularly important link between professionals and the families receiving services.

Finally, an important part of the structure of Integrated Family Services are learning groups, which are part of the commitment to ongoing training and offer room for discussion and additional learning in a consistent, routinely scheduled manner. In the case of services to very young children and their families, learning groups include wraparound facilitators, the child developmental specialist, a certified alcohol and drug counselor, a family resource developer, and two therapists. Learning groups meet once a week for one and a half hours. At the start of the grant, learning groups emphasized learning the wraparound model; now they can focus on particular issues that arise in the design and delivery of services. For example, case consultation can be a large part of the meeting, as can a didactic presentation. Learning groups provide an important opportunity to develop skill competencies together.

Promising Practices

Promising practices in early childhood services at the Community Wraparound Initiative are primarily reflected in their philosophy and in the design and delivery of services. Services in Lyons, Riverside, and Proviso Townships particularly focus on the individual needs of parents, the individual needs of children, and the needs of the family as a group. Staff have made a serious commitment to services that adopt a wraparound approach and to the role of families (as paid staff) in the design and delivery of services. Finally, links to formal and informal supports within the early childhood community are also critical to the services to very young children and their families at the Community Wraparound Initiative.

Individualized Services

Administrative staff draw on a state-level commitment to an individualized and wraparound approach, and they emphasize the benefits of this approach in the larger child-serving community. They also focus on imparting the value of this commitment to all staff and encourage and support staff in implementing this approach, even when that implementation is difficult, time-consuming, and discouraging. In one wraparound meeting we attended, we saw a clear commitment to working through differences of opinion between the parent and a provider. When a disagreement came up, the entire team looked again at the goals the parent had developed and discussed issues of accountability and follow-up. Because the focus was on goals that the parent had developed and that the team had agreed to support, the team was able to find consensus. In the case of very young children, this approach leads to considering and respecting the whole family in the design and delivery of services.

Community-Based, Family-Centered Services with Family Participation

The staff at the Community Wraparound Initiative worked hard over a few years to fully implement the roles of the family resource developers. It was not easy to build these positions, and their particular responsibilities, into existing structures. At the same time, these staff have been central to successfully serving very young children and their families. Staff have learned that parents often talk more easily to other parents about what they need than to other staff. Many families may be receiving respect for the first time. Family resource developers play a critical role in developing the "safe space" that parents need to accomplish significant changes in their lives. Because family resource developers can offer this safety and the necessary supports, very young children receive more attention in terms of their behaviors and developments. Because family resource developers often live in the same communities as children and parents who are receiving services, they have a strong connection with both child-serving agencies and informal and formal supports in particular communities and neighborhoods.

Coordinated Services

A wide range of child-serving agencies is often involved in offering services to children and their families. When those agencies do not communicate well, or have extremely different approaches to serving children and families, the results can be particularly hard on the families themselves. Staff at the Community Wraparound Initiative who provide services to very young children have worked hard to develop and maintain links with informal and formal supports throughout the communities. They have invested in long-term relationships with staff at other agencies in the early childhood community and have built connections with informal support networks that exist on a neighborhood-to-neighborhood basis. The result of this effort is that staff are aware of and in frequent conversation with agency staff who can provide resources that are vitally important to families and very young children.

KANFOCUS AND PROJECT BEFORE, SOUTHEASTERN KANSAS

Several programs serve families in the 13 counties of southeastern Kansas. Five mental health centers serve these counties, which employ a decentralized model for delivering mental health services. Initiatives developed under KanFocus, a Community Mental Health Services for Children and Their Families Program grant program that has graduated from federal funding, are being sustained by state funding and support multiple case managers and parent specialists to facilitate wraparound and continuum of services in the five mental health centers.

Project Before offer services to very young children and their families. A supplemental grant for early intervention services was the impetus for Project Before; state-level funding now supports services at a reduced level. Project Before allowed four mental health centers to add two staff members. Discovery

Head Start is a community-based psychosocial treatment program conducted in partnership between a mental health center and Head Start. In southeastern Kansas, the developing family advocacy organization Parent T.E.A.M.S reports that families of young children, particularly grandparents, are becoming involved.

As in the other grant communities, promising practices for very young children and their families in Kansas have strong links to the principles of early childhood mental health services we articulated earlier. Wraparound services, collaboration with other child-serving agencies, and individualized services are key components.

Philosophy

KanFocus, a Children's Mental Health Initiative grantee community, and Project Before, an early intervention supplemental grant in southeastern Kansas, have applied the principles of systems of care to providing early intervention services for very young children and their families. Important components of their approach of designing and delivering services include careful attention to the wraparound approach to working with very young children and their families and extensive coordination of services available to very young children and their families in southeastern Kansas.

Project Before draws on the Healthy Families America program[cxli] and combines a wraparound approach to service delivery with frequent home visiting. Case managers often visit families of very young children in their homes. They begin with a strengths discovery and a family-centered assessment. A child and family team is selected, and the parents, with the support of the rest of the team, decide on specific goals and objectives. Staff at Project Before have observed the benefit of wraparound teams in serving very young children and their families. In most cases, members of a small wraparound team, comprising the case manager, who is also the home visitor; a family member (or family members); and one or two people close to the family, such as extended family and friends, work together to accomplish specific goals for the child and the family as a whole. Close relationships have also developed with local health departments.

Services

Staff in southeastern Kansas deliver services to very young children and their families through a number of programs. In Project Before, services are delivered within a wraparound approach that includes home visiting and attention to the strengths and needs of the family and the child(ren). Discovery Head Start is a partnership between the Southeast Kansas Head Start program and the Community Mental Health Center in Crawford County (one of the 13 counties in southeastern Kansas) and provides a summer program for very young children to help them get ready for school.

Project Before

Whole family wraparound planning is the framework for planning and delivering services in Project Before. The whole family wraparound team consists of the family, the case manager, and one or two other people. Project Before intentionally keeps the teams small, as the families prefer, so that the family will not feel intimidated. Service delivery begins with an assessment of the strengths, preferences, and cultural practices of the child and family. The team, and particularly the parents, identify protective factors, risks, needs, and goals. Given this assessment, the team and the family develop a vision for the future that is based on their strengths, interests, and objectives for their child and the entire family. A home visitor may meet with a family in the home once or twice a week and coach the parents about how to meet the needs of their young children and how to discipline effectively. When needed, mental health therapists from the community mental health center provide in-home therapy. Case managers in Kansas work with a variety of specialists, including a child psychiatrist with a specialty in early childhood.

Project Before targets families in which a caregiver is affected by substance abuse or mental illness. Thus, services focus as much on the parents as on the children. Families of very young children often identify food, shelter, medical care, and other basic needs as their primary concerns and are less willing to participate in extensive mental health assessment or services until those needs are met. Through frequent home visits, the case managers can carefully assess the strengths and needs the parents have and be attentive to their situation and its challenges. In addition to providing resources and supports for the parents, Project Before staff make efforts to involve extended family and natural supports in the process of building a support system for the family.

Project Before case managers also pay special attention to preschool children in the home. Through observations and discussions with the parents, they work with the family to identify parenting strategies and discipline plans that fit the family environment. If a child within the family has a special need, the Project Before case manager works with the family to find resources to meet that need. The Project Before case manager can also go to the child care provider, preschool, or Head Start program with the parent and help work out transition issues among child care, preschool, and kindergarten programs.

Offering wraparound services can be difficult when the case manager wishes to address an issue that is not a priority for the parent. For example, Project Before staff do not address issues related to the parents' substance abuse or mental illness unless and until the family identifies these issues. However, as one case manager remarked, "You still work with it even if the parent doesn't want to address the substance abuse straight on. For example, you still need to talk about a safety plan for the children when Mom is drinking." An important part of the success of Project Before's services is an insistence on letting family members take a leading role in defining goals and objectives.

The rural setting and the lack of resources close to where families live can be a challenge in delivering services. An innovative approach to this challenge was demonstrated in Parsons, Kansas, where the case manager took three of her young clients to the local recreational facility for a "Friday Fun" day of open recreation and planned activities for all children in the community. The case manager transported the three children, stayed with them during the activities, and then returned them home. Although she was available to help her three charges if any problems or disputes arose, she did not spend all of her time with them. She helped the recreational staff with all the children in the program and often provided "on the spot" consultation about managing a child's difficult behavior. The children were engaged in social interaction in a community setting, and the parents got a four-hour break.

Discovery Head Start

Community-based psychosocial treatment programs are often needed in early childhood. Discovery Head Start is an innovative partnership between Families and Children Together, a part of the Community Mental Health Center of Crawford County, Kansas, and the Southeast Kansas Head Start program. Located in Pittsburg, Kansas, Discovery Head Start is an eight-week summer program that runs a double session from 8:00 A.M. to 11:00 A.M. and 12:00 noon to 3:00 P.M., four days a week, for 20 children in each session. Fridays are reserved for staff and team meetings and meetings about specific children. The program is housed in Head Start classrooms, and Head Start provides breakfast and lunch and transportation.

Discovery Head Start offers a summer program for children with identified emotional problems to help them work on their social skills and get ready for school. Among the enrolled children, 75 percent have an emotional or behavioral problem and 25 percent are considered "model children." This same mix of children is used in the Discovery psychosocial day treatment program during the school year. The children are between 3 and 5 years old, although most are 4 or 5.

Mental Health and Head Start jointly screen children who apply for the summer program. Some of the children have been in the Discovery program during the school year; others are from Head Start. Most children are low income and are eligible for Medicaid reimbursement, although this is not a requirement. Model children are recruited from the community in general and are not difficult to attract.

Discovery Head Start based its curriculum on the Boys Town Social Skills Training Curriculum; programming involves adventure-based games and initiatives interwoven with play. Staff work with each child (including model children) to identify a "target behavior" that he or she works on for several days. At the end of each day, the small group grades each child on how well he or she has accomplished the "target behavior." After the child has managed the target behavior successfully for several days, a new target behavior is set. Information about the child's progress toward his or her behavior goals is sent home to the parents each week.

The blending of the two staffs has many advantages and enriches the program's services. For example, staff from each program can identify information or activities that they have adapted from the other program. The Head Start director believes that involvement in the summer program has helped her staff offer more appropriate supports to children who might show challenging behaviors. The lead teacher from Discovery can identify activities and ways of working with parents that she has adopted from Head Start. Head Start staff marvel at the relaxed paper work in the summer, whereas staff from Discovery comment on the increased number of regulations. Because the Discovery program does not have food service available during the school year, the addition of nutritious meals is a real bonus. The Mental Health Center provides custodial services by contracting with their Adolescent Job Training Program. Youth with serious emotional disorders and their job coach come to the classroom at the end of each day to clean up and prepare for the next day's activities.

Structure and Financing

In southeastern Kansas, Children's Coalitions have been established at the county level and provide a structural framework for understanding the organization of services to very young children and their families. These Coalitions are a focus for bringing together the relevant leaders to identify needs and find solutions to service gaps for very young children and their families in the community. In 1992, the Kansas legislature passed a bill that mandates the organization of a regional interagency coalition of child-serving agencies, which further supports collaboration and community involvement.

Coalitions involve family members and, to some extent, business, civic, and religious leaders, as well as agency staff. Teams from most of the Children's Coalitions have been trained in wraparound facilitation, and many now take responsibility for initiating and facilitating wraparound teams for families involved with several agencies. The Children's Coalitions manage and allocate the flexible funds available through KanFocus and other sources. The Coalition meetings are excellent forums for identifying gaps in services, collaborating on grant-writing activities, and solving problems in the local service delivery system.

Staff at Project Before have found that serving very young children and their families calls for a wide range of skills and for particular knowledge in issues relevant to very young children. For example, services improve when staff are aware of typical and atypical child development. Further, skills for working with families, especially those under stress, and with adults who may have substance abuse or mental health problems, are important.[cxliii] Project Before chooses to employ bachelor's-level staff to work as case managers. Overall, a diverse staff of different ages and specialties, as well as parents and nonparents, seems to work best.

Additionally, case managers draw on an array of specialists and active supervisory resources to deliver services. The case managers in southeastern Kansas have a well-developed collaborative relationship with one child psychiatrist who has particular expertise in working with young children. This individual's name came up as a resource in almost every county we visited. In short, consultation offers a way to access specialized knowledge that is particularly relevant to young children and that may not be available on a full-time basis because of supply or cost.

In the case of Discovery Head Start, staff organization blends staff from the Discovery day treatment program and from the Head Start program. Discovery Head Start pays for all the staffing costs, and the lead teacher comes from that program. Staff from either program serve as small-group leaders or class aides. Head Start staff provide transportation and family outreach functions, which are similar to their roles in Head Start during the school year. This blended staff is brought together for a week of training and planning prior to the beginning of the summer sessions. Ongoing mental health consultation and the service of a public health nurse are available from Crawford County Mental Health.

Medicaid reimburses Discovery Head Start for the psychosocial day treatment program for low-income children who have a diagnosed mental health problem. No reimbursement is sought for model children. The program is free of charge to all parents. Head Start contributes space, utilities, and transportation. According to the program director of Children's Mental Health Services, the program breaks even and does not require general funds for support.

The children's mental health program, Families and Children Together, contracts with Southeast Kansas Community Action Program Head Start to offer two hours of a psychologist's time each week to each Head Start classroom. The program can use this time in a variety of ways, such as having the psychologist provide on-site training for staff and for families. Consultants may be asked to sit in the classroom and observe specific children or the whole class. Teachers can use this resource to develop plans for children in the classrooms, and the mental health consultants are often included in staff planning meetings. Parents can schedule time with the consultants to discuss concerns about their child or about themselves and other members of the family. Finally, staff can access this resource for help with their own concerns. It is clear that child care centers and Head Start programs will continue to be central locations for serving young children. They are therefore critical settings for mental health services for very young children.

Promising Practices

Services to very young children and their families in southeastern Kansas draw carefully and thoroughly on a wraparound approach to service delivery that supports close attention to the entire context of the family. This approach encourages sensitivity to the issues with which the parent(s) may be working. This attention to parents and the challenges they face often results in better parenting. In addition, relying on home visits to offer services gives the case manager and the wraparound team a chance to work with the parents and child in their own context. They can often pick up both strengths and needs in the home environment that they might miss in an office setting. Finally, the work of Discovery Head Start is an excellent example of collaboration among child-serving agency in the community and is an example of a mental health agency working with an educational setting.

Individualized Services

The staff at Project Before are especially attentive to how an individualized approach to the design and delivery of services might best meet the needs of the families they serve. Throughout the assessment and service delivery process, staff work with families to decide on and work toward particular goals and objectives. Parents have an important role in establishing priorities and in identifying strengths and needs; likewise, wraparound teams are small, in agreement with family preferences in southeastern Kansas.

Community-Based Services

Southeastern Kansas is largely rural. Families may live a considerable distance from a mental health center or may rely on public transportation. Offering services in the context of the home is particularly supportive to these families and also allows the case manager to observe the family and child in the home environment.

Coordinated Services

Discovery Head Start offers a model for a range of agencies offering early intervention services. Everyone can benefit when agencies serving very young children and their families combine efforts. The staff at the Head Start program have acquired useful information about children and mental health issues. Staff from the mental health center have built relationships with staff in an educational setting and have benefited from the practices and philosophy of Head Start. In a broader sense, cross-agency work between these two agencies is a model for the larger child-serving community in southeastern Kansas.

THE KMIQHITAHASULTIPON PROGRAM, INDIAN TOWNSHIP, MAINE

The Kmihqitahasultipon Program serves children and families of the Passamaquoddy Tribe of Indian Township, Maine. Initially funded by Wings of Maine, the Kmihqitahasultipon Program began receiving funding as a grant community independently of Wings of Maine in 1997. The Kmihqitahasultipon Program, the name of which means "we remember" in Passamaquoddy, works with a major goal of "restor[ing] Passamaquoddy culture and traditions to the daily life of Indian Township families and children for the purpose of improving overall community well-being." Based on Passamaquoddy tribal values and beliefs, the Kmihqitahasultipon Program is "bringing back what was once here." The project offers home-based care consistent with Passamaquoddy approaches to healing and community well-being in a population of 900 people, 60 percent of whom are under the age of 24. The 27,000-acre reservation covers seven miles from tip to tip.

The main health service provider for the Passamaquoddy community is the Indian Township Health Center. The Kmihqitahasultipon Program is one of the arms of the Health Center and is the primary provider of behavioral health services for children and their families. The Passamaquoddy community has a large population of single mothers, many of whom have had some trauma in their lives. Because a large number of families in the Passamaquoddy community have experienced some kind of trauma (from time spent in boarding schools, separation from the community, or abuse), the Kmihqitahasultipon Program in many ways considers the entire community when designing and delivering services. If a family has more than one very young child, the program often works with all the children in that family.

Promising practices in Maine are strongly linked to coordinated, individualized, and community-based services. A considerable amount of time and effort has gone into staff training and development. Staff are extremely attentive to their roles, their strengths, and their ways of working together to offer services. The lack of services for the Passamaquoddy community makes coordination among staff particularly important. Further, interventions are relationship-based and frequent; staff may visit a mother and her child several times a week, working on issues of support for the mother as well as for the child.

Philosophy

Attention to goals and philosophy has always been integral to the services the Kmiqhitahasultipon Program offers. When the program started, all staff devoted a month to intensive training and development. During this time, goals and objectives, as well as an approach to services, were worked out and articulated. This early and extensive attention to staff relationships and program objectives has served the program and community well. The Kmiqhitahasultipon Program has four primary philosophical commitments: (1) a focus on the strengths, roles, and responsibilities of staff, as well as their working relationships; (2) frequent, relationship-based interventions and supports for children; (3) cultural competence; and (4) a strong connection to the community.

Staff in Maine have a clear understanding of the strengths and responsibilities of each staff member, and they understand the overall needs of the program and community. As one staff member commented, there is a strong sense of respect for what each person knows and brings to the table. When differences arise, all staff share a commitment to talk through the reasons for the disagreement. Because of the high level of commitment of the staff to their own participation in designing and delivering services, they are able and willing to teach and learn about one another's skills and contributions. Ultimately, this results in more effective services for children and families. Staff meet weekly for up to half a day to discuss services in general and the needs of individual children and families. These weekly meetings help staff remain clear about the goals of the program and give the space and time necessary for talking through differences and coming to consensus.

A second component of the Kmiqhitahasultipon Program's philosophy is based on the recognition that in the community, very young children benefit from frequent, relationship-based interventions and support. Program staff clearly recognize that children and families benefit from frequent support from and contact with staff and have worked to make these kinds of interventions possible.

Cultural competence, including attention to cultural differences within the community, is also an integral component of the program's philosophy. All staff, except one, are Passamaquoddy. Several speak Passamaquoddy and thus can offer services in both English and Passamaquoddy. Expression of Passamaquoddy culture and values is by no means uniform. Further, in terms of evaluation, assessment, therapeutic interventions, and other components of services to very young children and their families, the Kmiqhitahasultipon Program staff do not assume that models of service and evaluation developed outside of their community will work. Staff must consistently review and discuss the underpinnings and assumptions present in service delivery models developed in a context other than their own.

The Kmiqhihatasultipon Program has worked hard to build relevant working relationships with individuals and organizations in the community. At one level, community members can act as providers, spending time with very young children and perhaps their parents (see "Services" section for additional information). Working with community members in this way broadens the support base available to very young children and their families; draws the community into the mental health system of care; and supports links among families, mental health providers, and the community itself. Further, program staff work closely with local organizations to increase knowledge about mental health issues and to encourage more optimal environments for all children. Through providing services, community members become linked with the Kmiqhitahasultipon Program and become more aware of and sensitive to the mental health challenges of very young children and their families.

Services

The Kmiqhihatasultipon Program offers a range of services to very young children and their parents and has an impact on the local educational system. Before we discuss the program, though, we need to set services in the Passamaquoddy community in context. Services based off the reservation have been and are available to people in the Passamaquoddy community. However, these services have not always served children and their families well. Obstacles range from the challenge of driving to off-reservation agencies to culturally inappropriate services offered by providers outside the Indian Township. For these reasons, and because the Indian Township Health Center is the central and only location of health care services within the Passamoquoddy community, the Kmihqitahasultipon Program designs and delivers all mental health services for children ages 0 to 5.

Services to very young children often begin even before the child is born. Program staff visit a pregnant mother and offer support and valuable information for new mothers. Regular meetings with the soon-to-be mother (and sometimes father) ensure that a strong relationship between the parent(s) and program staff is in place when the child is born and that the mother and provider are in a good place to address the needs of the child.

When the family begins receiving services, one of the two Child Behavior Specialists meets with the adults in the family and begins to work with them to articulate ways to address the challenges they are facing. These staff members also observe children in their natural settings. Most children ages 0 to 5 are not in school or in day care; therefore, the staff of the Kmiqhitahasultipon Program are the "eyes and ears" that notice challenges the child is facing, and they connect the child with the appropriate services.

The Kmiqhitahasultipon Program offers a variety of creative outpatient services. Providers are often people from the community who can offer individualized support to a very young child. Young children are helped through various play and interaction activities. In Maine, providers might visit a home twice a week for an hour to play with the child or engage in a favorite activity or might play with the child outside of his or her home, offering support for the child and respite for the mother and siblings. For example, a provider with appropriate water safety skills might go with a young child to a local swimming area.

The full-time parent advocate at the Kmiqhihatasultipon Program offers valuable resources to parents of very young children. In her experience, the most important part of the process is developing a supportive and trusting relationship with the family member. When this relationship is in place, the parent advocate is able to provide many supports to the family member, including

- help with parenting skills;
- respite;
- willingness to listen to family members on a regular and ongoing basis;
- facilitation of communication between parents and teachers; and
- information for family members regarding various community supports.

The parent advocate has developed close working relationships with teachers, which ultimately results in better services for children and their parents. Through her work with special education teachers, the parent advocate has increased their understanding of very young children and mental health issues and, in turn, has helped parents support their children as they begin school. The parent advocate has brought together teachers and parents in the same education workshops. This helps teachers learn about the challenges that parents face and leads to parents who are more informed about the teachers' responsibilities. In particular, as children transition into kindergarten, the teachers might have an increased awareness of mental health issues and a connection with the Kmiqhitahasultipon Program staff.

Structure and Financing

Mental health services fall under the Passamaquoddy tribal government. When we conducted our site visit in summer 1999, most Kmiqhitahasultipon services were funded through the Community Mental Health Services for Children and Their Families Program grant. The program can receive state money, but this source of funds is usually contingent on using non-Passamaquoddy providers. Currently, staff at the Kmiqhitahasultipon Program are working with state officials so that the services staff members provide might be reimbursed through Medicaid. Staff involved with this process point out that the program is delivering culturally competent services to the Passamaquoddy community and that the state of Maine will gain from the support the Kmiqhitahasultipon Program offers to families.

The Kmihqitahasultipon Program in Maine works closely with a community health care center and with adult mental health services. In part because of this close connection, the staff are able to meet weekly with their colleagues in the Indian Township Health Center who are providing mental health services to adults. These staff members can discuss issues relevant to families in which both a child (or children) and a parent (or parents) are receiving services. Staff of the Kmihqitahasultipon Program also benefit from a twice-monthly consultation with psychologists from Harvard University. Video conferencing is used to discuss a particular case the Kmihqitahasultipon Program staff present.

Promising Practices

Staff at the Kmiqhitahasultipon Program have developed a broad, comprehensive array of early intervention services for very young children and their families. These services are potentially available and accessible to anyone in the community; supports for parents may begin even before the child is born. Promising practices at the Kmiqhitahasultipon Program are strongly linked to their philosophical priorities and include attention to (1) the strengths, roles, and responsibilities of, as well as the working relationships among, staff; (2) frequent, relationship-based interventions and supports for children; (3) cultural competence; and (4) a strong connection to the community.

Coordinated Services

From the inception of the program, staff at the Kmiqhitahasultipon Program have attended to the importance of staff relationships and roles. An initial intensive five-day-a-week, four-week-long orientation and training program offered the staff a unique opportunity to learn one another's strengths and areas of contribution, as well as to focus on their collective vision and goals for the program itself. This early commitment continues with weekly half-day meetings among all staff and a commitment to understanding each staff member's approach to services and to understanding the best way for the staff to work together to serve very young children and their families. In this sense, staff are particularly aware of their own specific strengths in providing services, as well as of how to work with colleagues so that everyone's abilities are used well.

Individualized Services

Staff at the Kmiqhitahasultipon Program are in a unique position to know their community well. Experience has shown that close and ongoing attention to relationships with people in the community, and particularly with the very young children receiving services and their families, can lead to improved services. Staff at the Kmiqhitahasultipon Program have learned that especially in the first years of a child's life, frequent home visits and a range of supports for the parent(s) and the child(ren) can make a significant difference for the family as the child grows older. Staff at the Kmiqhitahasultipon Program pay particularly close attention to culture. The program serves largely Passamaquoddy families, as well as children and parents who may be of European American or mixed heritage. There are often meaningful variations among and within these groups. Further, most of the mental health assessment and diagnostic tools for very young children have not been developed with Indian children in mind. Staff can best serve very young children and their families if they change assessment and diagnostic tools when they are not appropriate for the community in which they work.

Community-Based Services

Staff at the Kmiqhitahasultipon have intentionally built links with other child-serving agencies in the community, which have resulted in improved services for very young children and their families. For example, the Parent Advocate has worked with teachers and has made intentional efforts to bring teachers and parents together. Parents now have a better understanding of the roles and responsibilities of teachers, and teachers better understand the mental health issues of children. This has been particularly important for children with mental health challenges transitioning into kindergarten. At another level, the Kmiqhitahasultipon Program has drawn on community members to act as providers, which results in the community being better informed about the Program and about children's mental health issues.

POSITIVE EDUCATION PROGRAM, CLEVELAND, OHIO

The Positive Education Program in Cleveland, Ohio, has been providing services to children ages 0 through 5 and their families for more than 20 years. In addition to two Early Intervention Centers, the program offers a three-year home-visiting program to at-risk parents, many of whom are teenage or first-time parents, as well as intensive day care consulting services on issues related to mental health. The range of services offered is both broad and deep; services are free of charge.

Parents have significant responsibilities in the Centers. During our visit to the two Early Intervention Centers at the Positive Education Program, we clearly saw that parents who have had children in services are critical to the services offered and are centrally involved in the design and delivery of services as paid staff members. Parent-staff give tours to parents interested in the program; observe parent-child interaction in structured sessions; record parent and child behavior during sessions; discuss the sessions with parents immediately afterward; work as classroom coaches in the day, afternoon, and evening classrooms; and actively participate in team meetings. Team meetings minimally include the family member(s) of the child receiving services, a parent-staff member, and a professionally trained resource consultant. Professionally trained staff are at both Early Intervention Centers to offer support and their expertise to the process of parent-staff working with parents who currently have children in services.

The Positive Education Program offers an excellent example of individualized and family-centered mental health services to very young children and their families. The range of programs, including the Early Intervention Centers and the Early Start and the Day Care Plus programs, ensures that a wide variety of supports and services dedicated to early childhood mental health are available for parents of young children and for those in the early childhood community.

Philosophy

The Positive Education Program has clearly articulated goals and a philosophy that supports these goals. As noted on their web site, the Early Intervention Centers have the following aims:

1. To serve troubled and/or troubling children and their families with needs so extensive that public schools and community agencies have been unable to serve them;
2. To assist clients in increasing their emotional, behavioral, and decision-making abilities;
3. To enable clients to return to less restrictive environments;
4. To support clients' maintenance of gains in follow-up; and
5. To assist families in becoming stronger and more stable and to help parents learn more effective interaction patterns with their children.

The Early Start home visiting program "provides support and services that promote the well-being of children birth to three and their families." The Day Care Plus program aims to "improve the social, behavioral, and emotional functioning of children at-risk in the day care setting, and to increase the competencies of the family members and the day care staff." Although the goals of each program are particular to the context and population it is serving, the philosophies of the programs are very similar.

The Early Intervention Centers, Early Start, and Day Care Plus all operate within the larger context of the Positive Education Program, which offers a range of services to children of all ages. The directors of the Positive Education Program and the early intervention services and the program coordinator of one of the Early Intervention Centers stress that the explicit attention to philosophy is a central factor in the program's success. In the context of the Positive Education Program's early intervention services, the main components of this philosophy include a commitment to services that have the following characteristics:

1. *The services are parent-implemented.* The Positive Education Program acts on a commitment to family participation in services. More than half the staff at the program are parents of children who have received services through the Positive Education Program. Parent-staff at the Early Intervention Centers work as session coaches and classroom coaches, providing support and teaching strategies to parents to work with their child's challenging behavior. Staff with mental health and early childhood training work as resource consultants, offering mental health knowledge to parents and session and classroom coaches and interacting with other early childhood providers. In our site visit to the Positive Education Program, it was clear that session coaches, classroom coaches, resource consultants, and the clinical supervisors at the Early Intervention Centers have important and integrated roles.
2. *The services are based on a model of health and well-being (rather than illness or deficits).* Services to children and families build on developing and maintaining wellness. Parents of children receiving services set goals for their children that emphasize appropriate behavior in the settings in which the children interact with others. Progress is evaluated by the ways in which the child accomplishes behaviors that move him or her toward these goals. When we sat in on a 90-day review, we saw the session coach and resource consultant emphasize what the child was doing well. When the mother brought up areas where she felt the

child was exhibiting inappropriate behavior, the session coach and resource consultant pointed out that this behavior was an improvement over previous behavior and drew out what was positive about the behavior.

3. *The services are experiential.* Parents who enroll their child in an Early Intervention Center must commit to coming with their child three times a week for three hours a day. Classes are held in the mornings, afternoons, and evenings and on Saturdays. For about 30 minutes each day, the child and parent interact around certain tasks or objectives. After 20 minutes, the parent discusses the interaction with the session coach and sometimes the resource consultant. For the remainder of the three hours, the parent is in one of the several classrooms, interacting with other children; that is, the parent and his or her child are not in the same classroom. The parent and the child practice behaviors and interactions repeatedly. Additionally, the parent can practice and observe how staff with mental health training interact with children with challenging behaviors in the classroom setting.
4. *The services are ecologically focused.* Staff delivering services at the Early Intervention Centers, Early Start, and Day Care Plus pay careful attention to the range of factors influencing the child and the family. Often, siblings will participate in the classroom and in sessions with the child and parent. Session coaches, at the parent's request, can go to the grocery store or to any other setting with the parent and child to observe the child's behavior outside the classroom.
5. *The services are based on the re-education principles of Nicholas Hobbs.* Nicholas Hobbs, a psychologist, articulates in *The Troubled and Troubling Child* several principles that directly address how child-serving agencies might best serve children.[cxliii] All staff receive training in these principles; additionally, the Positive Education Program will partially subsidize staff attendance at a Re-Education Association conference, which occurs every other year.
6. *The services are implemented through shared decision making at all levels of services.* The director of the Positive Education Program stressed the fact that "authority rests in the hands of frontline staff… When it comes down to it, the frontline staff make decisions." He pointed out that frontline staff are supported by a host of specialists. Also, he observed that theirs is an "open system" and one in which new ideas are welcomed. Indeed, in our site visit, it was apparent that parent-staff have considerable autonomy and responsibility when it comes to interacting with parents and with children receiving services.

Services

Early intervention services at the Positive Education Program are offered through three distinct programs: the Early Intervention Centers, Early Start, and Day Care Plus. All three programs work in the same county, and all three operate with a similar philosophical approach. Although the programs are distinct, they are also overlapping: a staff member who may have worked for five years in one of the Early Intervention Centers may move to a position in the Early Start program. Likewise, all three programs draw on similar models of offering services; the titles used to describe roles (session coaches, resource consultants, etc.) extend across all three programs.

Early Intervention Centers

As noted, the aims of the Early Intervention Centers are directly related to mental health issues. A child receiving services may have been referred by a school or other child-serving agency because of particularly difficult behavior. Likewise, the Early Intervention Centers focus on four basic steps in the treatment process: assessment/evaluation, identification of services needed, individual adaptations, and ongoing assessment.

The Centers offer services that include therapeutic play, social skills training, anger control training, problem-solving sessions, therapeutic groups, psychiatric monitoring and medication, individual counseling and behavioral intervention, and crisis management and intervention. It was clear in our site visit that the services that families and children receive go far beyond traditional mental health services; the benefits of the services often extend to all members of the family.

When parents call to inquire about the Early Intervention Center program (usually following a referral), they can set up an appointment to visit the Center. On arrival, the parents tour the Center with a parent-staff; if the parents have brought children to the Center, the children go into a classroom. If a parent decides to participate with her or his child, she or he must commit to attending a day or evening program three times a week, three hours a day with his or her child. All services are free. The parent fills out the required paperwork with a resource consultant, and a session coach watches the parent and child interact. Usually during the first week, the session coach makes two or three baseline assessments to get an overview of parent and child interaction.

The basic structure of services includes planned sessions, in-classroom time, and scheduled interactions in settings outside the classroom (including day care, the grocery store or bank, or the home). Sessions last 20 minutes; usually occur every day the parent and child attend the Center; and include Generalization Training (behavioral modification activities), the Transactional Intervention Program (speech and language development activities), and Individual Tutoring (focused skill acquisition and development). Generalization Training sessions usually focus on specific situations. On Fridays, session coaches are available to make outside visits and to practice specific behaviors with the parent and child in various community settings.

The parent has regular meetings with the session coach and resource consultant and has scheduled reviews of Individual Family Service Plans (IFSPs) and Individual Education Plans (IEPs). In meetings with the session coaches (which occur every day that the parent and child come to the Center), the parent asks specific questions, receives concrete feedback, and interacts with a staff person who has had a child receiving services. If the parent likes, or if the session coach chooses, the resource consultant can be brought in to the meeting to offer his or her input and expertise. In short, services at the Early Intervention

Centers are formal and informal; they are offered by parents who have had children in services and by staff trained in mental health and early childhood development; they emphasize both child behavior and parent-child interaction; and they offer parents the chance to expand their social support network and learn advocacy and parenting skills.

Early Start

Early Start is a program funded through the Ohio Department of Health, as well as through the county's Early Childhood Initiative, and is offered through 27 providers in the county (the Positive Education Program is one of these Early Start providers). Staff at the Positive Education Program began offering Early Start services in June 1998. Mothers who participate receive weekly, bi-weekly, monthly, then bi-monthly visits from a parent-staff home visitor for up to three years. Each home visitor works with approximately 40 families and, in most cases, develops a strong relationship with the parent(s).

The goal of Early Start services is to "promote the well-being of children birth to three and their families"; the program assumes that "a parent is a child's first and best teacher." When a parent becomes an Early Start participant, a parent-staff home visitor and a resource consultant from the Positive Education Program attend the first visit. The home visitor clarifies her role and explains how she can help the parent. The parent-staff and resource consultant do an assessment with the parent and the child(ren), and then the parent-staff conducts the remainder of the home visits. Typically, a visit lasts an hour, and the home visitor may become one of the main supports for that parent.

A home visitor that we met during the site visit stressed the value of the services that Early Start offers beyond parenting skills and strategies for improving the child's behavior. Often, it is important for the parent to hear that he or she can accomplish a particular goal, such as getting a certain job or certificate. Also, the home visitor works on a sufficiency plan with the parent and discusses education (particularly when the parent has not finished high school), child care, housing, and employment. The home visitor also encourages the parent to develop a social support network so that he or she can draw on others when necessary. In some cases, the home visitor may see that the parent could benefit from one or more social services, such as mental health services, and can offer the appropriate resources. Finally, the home visitor regularly discusses parenting skills and issues related to mental and physical health with the parent.

Day Care Plus

In 1997, a collaborative effort of the Cuyahoga County Community Mental Health Board, Starting Point for Child care and Early Education, and the Positive Education Program led to the establishment of Day Care Plus. This program works with day care centers in Cuyahoga County to "improve the social, behavioral, and emotional functioning of children at-risk in the day care setting, and to increase the competencies of family members and the day care staff." Day Care Plus offers both short-term and long-term support to day care centers. The director of a day care center can choose to work with Day Care Plus on a two-year-long intensive basis. Staff from Day Care Plus, and other early childhood specialists, work with the day care provider at the day care center once a week for two years. Day Care Plus is an especially relevant resource for parents whose children may have had difficulty in more than one day care setting.

Day Care Plus services are designed and delivered to support children, parents, and day care center staff. Having a child be asked to leave one or more day care centers can be a frustrating experience for the parent. The philosophy of Day Care Plus views most parents as willing to work at keeping their child in day care. Emphasizing collaboration among day care center administration and teachers, the child-serving community, and parents, Day Care Plus offers training, technical assistance, and consultation (at no charge) to day care centers requesting its services.

Although Day Care Plus staff acknowledge that not all centers will change in significant ways, many do. In some cases, a change in classroom environment will help a child feel more comfortable in that classroom. In other situations, Day Care Plus might write up a long-term plan with a day care center and map out specific goals and objectives. Day Care Plus staff work with a range of stakeholders in any given context. Although work between a day care center and Day Care Plus may begin with the problems one family and child have experienced, the services are designed to assist the day care center to better support learning for all children. Attention to the ways staff can respond to challenging behaviors, and work with parents, often results in better outcomes for the day care center as a whole.

Structure and Financing

The primary funders of the Positive Education Program's Early Intervention Services include the Cuyahoga County Community Mental Health Board and the Ohio Department of Education in addition to excess tuition costs paid by local school districts. In part because the Early Intervention Centers offer a classroom setting, they are designated an educational placement and thus receive Special Education funds. A recently begun three-year early childhood initiative has also offered significant financial support to the Early Intervention Services at the Positive Education Program. The initiative is $40 million, of which $30 million is from state, county, and other public dollars and $10 million is from private foundations. Already, staff at the Positive Education Program are looking at ways to continue the funding that comes from the Early Childhood Initiative.

The director of Early Intervention Services at the Positive Education Program stressed that its approach to funding has been significant to the design and delivery of services. Despite the increasing requirements of local and state agencies (which most often rely on a sickness, rather than wellness, model), staff at Early Intervention Services have been committed to developing programs that fit the strengths and needs of children and families. As the director of Early Intervention Services explained, the staff "set up the program, and then find the money that will support that program." Although she admitted that this is becoming more difficult, writing the program first allows services to fit the philosophy and emphasis on wellness that are integral to the program. Staff frequently write grants for specific programs. Although these grants are not large, they do result in funding for services. In short, to continue the funding that supports the services described earlier, Early Intervention Services staff must be creative, resourceful, and proactive, and they must consistently aim at services that reflect a wellness- and preventative-based approach to services for very young children and their families.

The staffing models are largely parallel across the three arms of early intervention services (including the Early Intervention Centers, Day Care Plus, and Early Start). Parent-staff serve as session coaches and classroom coaches; staff with professional training in mental health and early childhood act as resource consultants. Roles are clearly defined, which undoubtedly contributes to the success of the program and helps the work get done in flexible and individualized ways. Parent-staff have considerable autonomy and are as integral to the design and delivery of services as administrators and professionally trained staff.

In addition to session coaches, classroom coaches, resource consultants, and other classroom staff (including, in the full-day classrooms, a teacher counselor, an associate teacher counselor, and a team associate), the Early Intervention Centers draw on a range of mostly part-time staff resources. For example, a speech and language therapist works at both Centers, and two dance therapists visit the Early Intervention Center-West once a week. The Early Intervention Centers also benefit from staff who work for other arms of the Positive Education Program; two psychiatrists who work for the Positive Education Program each serve a half day at one Early Intervention Center, offering psychiatric consultation.

Promising Practices

Early Intervention Services at the Positive Education Program offer a range of concrete and relevant supports that make a difference in the lives of children and families. Services are built on a history of 20 years of early intervention services, as well as on a broad-based program that has steadily acquired community support and a strong record of accomplishment. Further, staff at the Early Intervention Services at the Positive Education Program successfully bring together family-staff with professionally trained staff in innovative and significant ways.

High Level of Family Participation

The Positive Education Program uses a model that values the resources that family-staff and professionally trained staff bring to the design and delivery of services. Family-staff are central to services; professionally trained staff serve as resources and support the work the parent-staff are doing with other parents and children. Further, the parents of children currently receiving services have an important stake in the program. To participate in the center-based services, parents must attend three days a week; this level of commitment helps ensure that families have a high degree of involvement in their child's progress and development.

Strong Focus on Needs, Strengths, and Resilience of Child and Family

In addition to focusing on particular developmental needs, staff at the Positive Education Program focus on health and well-being (rather than illness). Staff at the Early Intervention Centers, the Early Start Program, and Day Care Plus consistently work toward encouraging socially appropriate behavior. Parents whose children are receiving services work with parent-staff and professionally trained staff to determine goals for the child and family. The Center emphasizes the child's positive behaviors and positive interactions between the parent(s) and the child. Even when children struggle with their behavior, and when parents might be frustrated with the apparent lack of progress, staff consistently articulate what the child is doing well and how he or she has improved. Likewise, staff are particularly aware of both age-appropriate behavior for children and the parents' goals concerning their children.

Family-Centered Services

The Positive Education Program demonstrates a strong commitment to experiential-based services, in which the parents repeatedly interact with their children and receive support from the Program staff. Even in our site visit to Early Intervention Services at the Positive Education Program, we did as much watching what happened as talking about what happened. That is, parents and children in early intervention services practice how to improve the child's behavior. Clear goals are articulated, and at least three times a week, parents and children, with the support of early intervention services staff, work with specific, repeated, and tested exercises to improve the behavior of the child and the interaction of the child and the parent.

CHAPTER 4: DISCUSSION AND CONCLUSION

In this monograph, we have identified significant accomplishments, as well as challenges, in the field of early childhood mental health. Through a literature review and a discussion of our visits to five communities working with very young children and their families, we have described practice-based developments in the field and have reported on promising practices in the design and delivery of services.

This is still a young area of research and service delivery. Child-serving agencies in general, and mental health agencies in particular, assign different levels of importance to working with children who experience emotional, behavioral, and mental challenges and their families. Below, we review the primary promising practices that we found in our visits to the five communities working with very young children and their families in the light of findings from the literature. Following the overview of promising practices, we recommend directions for future research.

PROMISING PRACTICES IN EARLY CHILDHOOD MENTAL HEALTH

In our literature review and analysis of findings from site visits, we identified principles that reflect systems of care principles tailored to the specific developmental issues of very young children and their families. Systems of care serving young children and their families are guided by values and practice guidelines that are similar to those of systems of care for older children, but with the addition of knowledge and expertise related to early childhood developmental needs and the importance of nurturing environments. We found that services support the mental health of very young children when they have the following characteristics.

Services are family-centered. Supports and services are designed according to the family's strengths, needs, and preferences. "Family" is defined in the way the family defines it and reflects diverse and dynamic family membership and patterns. In addition, family-centered services are always connected to the degree of family participation in the design and delivery of services. In all the sites we visited, service providers pay particular attention to the strengths, needs, and culture of the family with which they are working. Programs offer both informal and formal supports to families and take specific steps to stay in touch with the challenges that families are facing. For example, in Illinois, Family Resource Developers often live in the same communities as the children and families they are serving and thus have a strong sense of each family's context.

Services are individualized. Programs and services respect families' racial, ethnic, cultural, and socioeconomic backgrounds and their values and beliefs. Interventions are tailored to address families' unique needs and strengths. Programs that serve families well take culture into account at all levels of service design and delivery. Services that are family-centered and individualized pay close attention to the social and environmental context, values, and beliefs of the child and family being served. Particularly when a child's and family's cultural assumptions and practices are not of the dominant culture, staff who recognize the uniqueness of each child and family are likely to also recognize cultural differences.

Many assessment and diagnostic tools have been designed on the basis of the social and developmental realities of European American and middle-class children. The Kmiqhitahasultipon Program in Maine is one excellent example of a program that has thought through the biases and assumptions within these tools and has made necessary adaptations. Attention to culture must not occur only at obvious levels (such as paying attention to the uniqueness of each family); it must also occur in connection with routine practices (such as the use of diagnostic tools) that may be time-consuming to change.

Services are comprehensive. Service arrays include a variety of interventions that take account of the developmental, health, and mental health needs of families and the potentials for health promotion as well as preventive and therapeutic interventions. All parents need support to raise children well. When providers focus on the health and well-being of the entire family, they consider that offering transportation, caring for the child's siblings when the parent and child are receiving services, and encouraging parents in regard to parenting skills (as well as parent goals and accomplishments, such as completing one's Graduate Equivalency Degree) are as important to parents as parenting classes and individual therapy. Supportive relationships with staff, and particularly with other parents, can make a significant difference for parents.

Intervention strategies that are family-centered to address the needs of the entire family are derived from ecological and family systems theoretical perspectives, which have been incorporated in early childhood mental health services.[cxliv] Wraparound approaches to service delivery attempt to meet the unique needs of families through individualized interventions in which parents play active roles in deciding what will be most helpful to their family.[cxlv]

Services are community-based. Community-based interventions incorporate informal supports that are found in the community and are offered in settings that are familiar to the child and family, such as the home or the day care center. Community-based services might mean that programs serving the mental health needs of very young children and their families build on existing services, as in the case of Vermont, instead of creating new ones. In all the sites we visited, staff pay attention to families' basic needs, such as food, housing, and employment, and are aware of existing services in the community to support those needs.

Services are coordinated. Since no one agency or discipline can meet the diverse, complex, and changing needs of young children with special needs and their families, coordinated services as well as transdisciplinary and transagency collaboration are appropriate. Families may interact regularly with multiple agencies and service providers. For example, at one time, a family may be working with a pediatrician, a speech therapist, and staff members at a Head Start program, child care center, and mental health agency. Further, services from different agencies can complement one another when there is coordination among agencies and collaborative relationships between providers. Service providers in Vermont have found that it works best to supplement existing services for very young children with mental health services and supports rather than build a new system or bring outside agencies into the children's mental health system. Illinois has also invested considerable time and energy to develop close working relationships with several state and local agencies that serve very young children and their families. When agencies that serve very young children and their families work together with close attention to the overlap and coordination of services, outcomes are likely to be better.

Services are built on a high level of family participation. Although family participation has been a common practice in early childhood services generally, it has been a challenge in the early childhood mental health service area in which families may be more stigmatized. Family-professional partnerships and collaboration are essential components of empowerment-oriented interventions. Families of children who have received mental health services are uniquely able to offer services to other parents. When there was a high level of family participation, professionally trained staff in the communities we visited recognized the particular strengths of parents as staff and providers: parent-staff are integrated into the communities in which those receiving services live; they are in a unique position to understand and address the challenges that parents are facing; and they have knowledge of the resources that parents and children need, advocacy skills, and the capacity to pass this knowledge on to other parents. Acting on this knowledge, staff members with mental health training had to play roles different from those for which they were trained. We noticed that when parent-staff and professionally trained staff worked collaboratively and shared decision-making responsibility, families said that they received the services and supports they needed.

Parent-to-parent support has traditionally been a central feature of Early Intervention, and it is increasingly being used in early childhood mental health. Parents' expertise and capacity for providing support to other families were recognized at the communities we visited. Yet, the model of parents as service providers is not as widespread as might be hoped, perhaps because the mental health field has traditionally been staffed by highly trained professionals. Head Start programs have been a leader in this respect, and Knitzer has provided examples of a number of early childhood mental health programs nationwide that feature parents in a variety of roles as service providers.[illegible]

At the Positive Education Program in Cleveland, family members who are paid staff members work with parents of children in the program, meeting at least three times a week with these parents. Further, the parents practice interacting with and supporting age-appropriate behavior with their children and receive regular feedback from parent-staff and from a professionally trained staff member. Finally, we found that parents remain engaged with and committed to their child's progress in a program when they have a high level of ownership in that program and when other team members rely on parents' participation in their child's progress.

As Dunst, Trivette, and Deal have pointed out, approaches that view families as competent and that have professionals and parents share decision-making power are more likely to result in the empowerment of families and better outcomes for their children.[cxlvii] Wehman has confirmed parents' essential roles in early intervention teams, in planning services for their child and providing services through training, teaching, and therapy.[cxlviii]

Services are focused on developmental needs. A focus on developmental needs has traditionally been central to Early Intervention. Recently, the field of early childhood mental health has expanded its attention to the multiple dimensions of child development. Awareness of age-appropriate behavior and cognitive and social development and attention to the particular goals and strengths of the child can help staff offer appropriate services to the child and their family. Many of the communities we visited offered support and education to the family members to make them aware of age-appropriate behavior and appropriate ways to intervene in their child's behavior.

Services are built on strengths and resilience. Interventions are designed to promote resilience in children and to build on family strengths by enhancing self-esteem, improving coping strategies, and increasing positive social support. We found that when services are designed and delivered to improve the well-being of the entire family and the general emotional and behavioral health of the child in all the settings in which he or she interacts, families and providers are more likely to perceive outcomes (child, family, and staff) positively; families feel supported and respected in their role as parents; and families are satisfied

A health promotion orientation is associated with approaches derived from the literature on resilience and protective factors and suggests that strategies designed to enhance resilience and protective factors in children, their families, and communities can be effective.[cxlix] The introduction of brain-scanning techniques for pinpointing the source of emotional and behavioral problems has contributed to developing new knowledge about critical periods of brain development and the capacity of the brain to overcome the effects of some kinds of injury.[cl] These developments point to the importance of creating safe and nurturing environments to promote children's healthy development. Knitzer has drawn attention to the positive effects on young children of early childhood interventions that enhance families' social support and coping skills and support effective parenting.[ch] Appendix D contains a summary of examples of how the principles for early childhood mental health we identified in our research are implemented at each community we visited. In addition, Appendix E features a collaborative program model for early childhood mental health based on the recommendations of Woodruff. This model offers a framework for viewing program-level and practice-level activities for health promotion, early identification, and comprehensive responses to family needs.[ci]

DIRECTIONS FOR FUTURE RESEARCH AND PRACTICE

Having only recently been identified as a priority group in children's mental health, very young children and their families have been the focus of limited research and service innovation. We have identified several promising practices and innovative strategies to meet the needs of young children with serious emotional disorders and their families and promote healthy development of young children. However, there is much that we do not yet know. Further research is needed to advance the knowledge of brain development in infants and young children and the conditions that promote healthy development. Evaluations of effective health promotion and early intervention strategies are needed, as is dissemination of findings about the most effective strategies for promoting healthy communities—especially in culturally diverse communities and those with significant economic and social disadvantages. In the final section of this monograph, we will highlight the need for further research to improve practice in the areas of cultural diversity and services; assessment, diagnosis, and treatment; family participation in services; and the relationship between early childhood policies and practice.

Cultural Diversity and Services

All staff in programs serving very young children and their families encounter people from a variety of cultural backgrounds in their work. Despite differences in how culture is perceived and defined, effective services for very young children and their families will recognize the existence of cultural norms and expectations that are always specific to individual families and are often connected to a particular group. Through our site visits, it was clear that services that build on the strengths of children and families can be more effective when they recognize the ways in which culture is operating for the child and in the family.

Further work is needed to develop diagnostic, assessment, and evaluation measures for use with very young children and their families. In addition to examining the child's developmental progress, useful instruments will address the contexts, strengths, and needs of children from diverse cultural and socioeconomic backgrounds. In Maine, staff members have revised existing tools and developed new ones to serve very young children and their families most effectively.

Future research and practice in the field of early childhood mental health will need to address culture in order to individualize services. As work in Maine has shown, there is also a need for the thorough exploration and study of various cultures in regard to early childhood developmental stages, diagnostic tools, and intervention practices. We believe that individualized, family-centered services are a way to address culture and that explicit attention to the cultural appropriateness of every level of early childhood service design and delivery is necessary.

Assessment, Diagnosis, and Treatment

Guralnick recommends the translation and integration of "emerging developmental and biobehavioral knowledge into highly individualized intervention strategies" to be evaluated using social competence as a central organizing concept to measure outcomes.[cliii] The development and refinement of risk indicators and clinical instruments will allow increased specificity in interventions so that they may be offered at varied levels of intensity to address children's unique developmental needs.[cliv] We also recommend further research regarding resilience and protective factors to clarify how these concepts may be used to guide the further development of effective family-centered services. Research has shown that risk and protective factors influence very young children and their development, but it is not yet clear how staff members serving young children and their families use this knowledge and how this use affects outcomes. How does using risk factors in assessment and intervention affect the design and delivery of services that are strength-based and oriented toward health rather than illness? In other words, how can staff focus on health and strengths and appropriately take account of risk factors?

All the sites we visited are working with children who experience both risk and protective factors. In Illinois and Kansas, funds are specifically designated to support services that work with parents who are at risk for, or are experiencing, behaviors that may negatively influence their child's development. In our site visit, we found that even when parents were engaged in behaviors identified as risk factors for very young children, staff consistently focused on strengths and health-based goals identified by the family. In light of this information, what is the precise role of risk and protective factors, particularly in the case of front-line staff delivering services to very young children and their families? More research in this area would add useful knowledge to the literature on risk and protective factors.

Family Participation in Services

Despite the increased attention to family participation in aspects of service delivery in early childhood mental health services, many programs must address significant family and system barriers.[clv] In the field of Early Intervention, Bailey, Buysse, Edmondson, and Smith found discrepancies between how professionals think parents should ideally be involved in early intervention programs and how they are actually involved.[clvi] A similar concern exists in the field of early childhood mental health: the potential gap between family member perception of family participation and professional perception of family participation. These authors suggest that training for family members should be available at several levels so that they are able to participate effectively in services at their preferred level of involvement.[clvii] Further, we recommend increased attention to family participation in professional training for early childhood mental health services.

In all the sites we visited, families are offering, and indeed providing, many services. Families work as full- and part-time staff and offer formal and informal supports and services. In Cleveland, for example, families who have had children in services work as classroom coaches and as session coaches. Session coaches observe parent-child interaction, assess the interactive process, and discuss the assessment with the parent. Research that addresses specific parent roles that complement professional roles in designing and delivering early childhood mental health services will offer insights to enhance parent-professional collaboration.

Relationships Between Policies and Practice

A final important area of future research is the complex relationship among funding, public policy, and early childhood mental health programs. As we point out in the literature review, early childhood policy has experienced several recent developments. In most of the sites we visited, systematic attention to how funding is directly related to policy, and how both are related to outcomes, is preliminary. Future research might look at how local, state, and national policies related to early childhood are affecting funding at several levels and, in turn, are affecting outcomes. The programs we looked at were very creative in the ways that they put together funding sources, often using special policies or policy interpretations to support services to very young children. It was not uncommon for programs to combine several small sources to fund services.

CONCLUSION

We have reported on site visits to five early childhood mental health programs and have featured several promising practices we found at those sites. In many communities, programs that address the mental health issues of very young children and their families are relatively new and small scale. Knitzer notes that the major changes in children's mental health in the last 15 years have largely ignored the needs of young children and that the current program response to the mental health needs of infants, toddlers, and preschoolers and their families is poor.[clviii] As she notes, at the policy level, no one entity has had responsibility for meeting the mental health needs of young children.

At the same time, preschool and elementary teachers are expressing growing concern (which has not yet been systematically documented) about the increasingly difficult behaviors in young children that they are forced to deal with. Knitzer reports that staff in early childhood and family support programs are seeking ways to recognize and meet the complex needs of families, especially those affected by substance abuse, mental illness, and depression in the family and violence in their community.

At this time, services for young children and their families are fragmented in most communities. No coordinated advocacy voice speaks for the needs of young children who have or are at risk of developing emotional or behavioral disorders. Recent policy changes, such as the Personal Responsibility and Work Opportunity Act and Adoption and Safe Families Act, require young parents (particularly low-income single parents) to develop the capacity for economic self-sufficiency and safe care for children even when the infrastructure for healthy care arrangements for young children is missing. It is too soon to determine conclusively the effects of these policies on young children, but there is potential for unintended adverse consequences on the healthy development of young children.

The stresses related to balancing work and family responsibilities, managing on a low income, and finding quality child care (especially for young children with emotional and behavioral disorders) are challenging for many families. Divorce rates remain high, violence is a common community problem, and substance abuse is a problem. Without family and neighborhood support, families need to know where they can turn for assistance and services. Affordable, accessible substance abuse treatment needs to be expanded, especially where the children and the entire family unit can receive services.

At the same time, there is growing attention to how formal and informal supports to families and communities can enhance their capacity to promote the healthy development of very young children. Health promotion activities and preventive and therapeutic interventions with young children and their families in the field of Early Intervention lead to short- and long-term positive outcomes, and much that has been learned in Early Childhood Intervention can be applied to early childhood mental health. New programs that advocate for and provide comprehensive health care for young children offer promising examples of innovative directions for children's mental health services. For example, the use of Proposition 10 dollars in California and the recently passed Children's Health Act expand the possibility of health promotion and individualized services. As we discussed earlier, California's Children and Families First Act (passed in 1998 and also known as Proposition 10) imposes an excise tax on the sale of cigarettes. Year 2000 revenues from this tax are expected to reach $690 million and will be used to improve early childhood development. Proposition 10's emphasis on comprehensive, integrated services to help children grow to their maximum potential offers a model for other states. A notable aspect of this Act is that early childhood mental health issues, along with other health concerns, are addressed in local communities.

The Children's Health Act of 2000 is another example of national levels of coordinated, broad-based efforts to support children's health and well-being. In addition to reauthorizing the Substance Abuse and Mental Health Services Administration, this Act offers a sixth year of funding to the systems of care funded through the Community Mental Health Services for Children and Their Families Program. Both Acts point to promising developments related to the mental health of very young children and their families.

Findings in the literature review demonstrate the growing awareness of the benefits of preventative and early intervention approaches in the early childhood field. The literature also points to a growing emphasis in service delivery on transdisciplinary and transagency models of collaboration, such as the one recommended by Woodruff.[clix] Further, theoretical frameworks based in ecological theory have led professionals in the field of early childhood mental health to include the transactions among child, family, and the community and the cultural contexts in which families live, rather than focus solely on the child.

Often paralleling the themes in the literature, staff in grant communities emphasized the value of services that are community-based, family-based, and individualized and that include a high level of family participation. Staff in the communities we visited also noted the significant benefits to intervening early in a child's life; these benefits are experienced by children, families, and the entire community. The primary guidelines and practice principles integral to early childhood mental health have strong parallels with mental health services to older children and their families. Careful attention to the developmental issues of very young children and knowledge of recent research in brain development are considerations that can distinguish early childhood mental health from programs that serve older children. It will be critical for staff designing and delivering early childhood mental health services to be attentive to the challenges unique to developing and delivering services for very young children and their families. Other early childhood providers may not agree on the importance of mental health, and mental health systems of care may direct services primarily toward older children. Further, funding for services for very young children is nearly always a challenge. Programs such as the Children and Families First Act in California provide much needed models of how to bring together public monies across service sectors in the early childhood field to offer comprehensive and community-based services directed at promoting health and addressing mental health challenges.

The principles and promising practices articulated in this monograph provide background for and insights into developing and sustaining early childhood mental health programs that improve the lives of children, families, and communities. We have described the specific ways in which five communities have developed local responses to the imperative to support mental health in families with young children. The challenges for the future will be to apply the principles we have distilled in our study in other local contexts and to replicate, create, or build on current efforts to respond to the needs of young children and their families.

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APPENDIX A: CONCEPTS RELATED TO EARLY CHILDHOOD MENTAL HEALTH

One of the biggest challenges to understanding the world of mental health services for very young children is understanding the language used and, more specifically, the names given to various programs and services. Because several different service sectors manage and fund services to young children, terms sometimes mean the same thing and sometimes have shaded differences in meaning.[clx]

Mental health promotion deserves inclusion at the beginning of this discussion. Mental health promotion activities help individuals obtain the highest level of mental well-being possible. A working definition is offered by Mrazek and Haggerty: "Mental health promotion activities are provided to individuals, groups, or large populations to enhance competence, self- esteem, and a sense of well-being rather than to intervene to prevent psychological or social problems or mental disorders."[clxi] Philosophically, mental health promotion emanates from a wellness stance unlike concepts that are grounded in an illness view of the world. As such, promoting mental health is not the same as enhancing protective factors because of the different philosophical basis.

The language of *prevention*, as proposed by the Institute of Medicine Report in 1994, helps us understand the relationship among the variety of terms used to describe the early childhood response to emotional and behavioral challenges. Used by Gordon[clxii] to refer to the prevention of physical diseases, the term *prevention* has three distinct applications: universal, selective, and indicated. In this framework, *prevention* or *preventive intervention* applies to interventions that occur before the initial onset of a clinically diagnosable disorder with the aim of reducing the occurrence of new cases of mental disorder.[clxiii] The three categories of preventive interventions follow (see box on page 92), accompanied by the definitions as they are given in the Institute of Medicine report. Examples from early childhood have been added.

The term *early intervention* crops up frequently in conversation, often without a precise meaning. At its most generic, early intervention refers to providing treatment or support before a problem becomes serious. In this sense, early intervention describes the timing of a sequence of events and not the content of the services or activity. For example, one might intervene early with high school students to keep them from dropping out of school. In this context, the intervention occurs early (before the student leaves school) but not when the student is young. Comparing this use of *early intervention* with the more precise meaning found in federal education legislation, such as the Individuals with Disabilities Education Act, may explain some of the difficulties we have with language.[clxiv] According to Thurman, "early intervention" may be defined as "an array of services that is put in place through a partnership with families for the purpose of

PREVENTIVE INTERVENTIONS: UNIVERSAL, SELECTIVE, AND INDICATED

- *Universal preventive interventions* are made available to the general public or to a whole population group with the goal of creating or enhancing conditions that will support the child's behavior and reduce the probability of challenges to the child's behavior. Examples are parent education programs that are made available to everyone in the community, or a family resource center that is open to everyone.
- *Selective preventive interventions* are targeted to individuals or subgroups whose risk of developing a mental disorder is significantly higher than average in order to reduce the incidence or severity of potentially challenging conditions or disorders. This might include groups who have biological, psychological or social risk factors. Selective preventive interventions "attempt to deal with core problems and may have many positive reverberations."[clxv] Examples and home visiting programs for teen-age mothers who have recently given birth support programs for families involved with drugs or alcohol.
- *Indicated preventive interventions* are targeted to young children who are identified as having minimal but detectable signs that suggest the risk of future development of a mental disorder. These interventions take place early in order to address the existence of the emerging disorder and to prevent the possibility of a secondary disability emerging. This could include the presence of a biological marker that suggests a predisposition for an emotional or behavioral problem but does not yet meet diagnostic criteria. Examples include a child who is born with the characteristics of fetal alcohol effect a child who is slow to develop social behaviors.

promoting their well-being and the well-being of their infants, toddlers, and young children whose development may be at risk due to a combination of biological and environmental factors."[clxvi] Under the 1997 Individuals with Disabilities Education Act Amendments, *early intervention* is a term used only when speaking about services to children birth through 2 years and their families that are provided because of the young child's identified disability. Other terms, such as *early childhood special education* or *preschool special education,* are used when talking about services for children ages 3 to 5.

The term *early intervention* variously refers to the timing of an intervention relative to when a problem occurs and to interventions with children anywhere between the ages of 0 and 5.

Despite the very focused meaning of *early intervention* related to the 1997 Individuals with Disabilities Education Act amendments, Thurman notes that more and more authors are using the term to denote services to children birth through 5 years of age regardless of risk, disability, or diagnostic status.[clxvi] This use is echoed in a recent Rand report in which early intervention is defined as "formal attempts by agents outside the family to maintain or improve the quality of life of youngsters, starting with the prenatal period and continuing through entry into school."[clxvii] The Rand report introduces another term, *targeted early intervention,* which refers to services that are targeted to children with disabilities or children who are known to be exposed to stressors: "Targeted early intervention programs promote the development of children subjected to one or more stressors."[clxviii] Used in this way, targeted early intervention is close in meaning to the terms *selective preventive interventions* and *indicated preventive interventions* found in an Institute of Medicine report.[clxix]

The final term for discussion in this section is *early childhood mental health*. This term is recent in origin and is still not uniformly recognized or accepted in either the mental health field or the early childhood field. Knitzer identifies the purposes and activities associated with the term: "The aim of early childhood mental health is to improve the social and emotional well-being of young children and families by strengthening relationships with caregivers, and promoting age appropriate social and emotional skills."[clxx] Early childhood mental health represents a combination of knowledge about the developmental process of young children and their families and mental health skills and expertise.

Defined in this way, early childhood mental health activities have a strong prevention overtone while maintaining a treatment or family support philosophy. Early childhood mental health overlaps with early intervention on the prevention end of the continuum, but extends further into the treatment and maintenance phases of work with young children and their families. A subset of early childhood mental health is *infant mental health*. Since the 1970s, this term has referred to a pioneering program led by Selma Fraiberg at the University of Michigan's Child Development Project, which has been expanded to become the Michigan Infant Mental Health Program, an intensive home visiting program for infants and their parents that operates statewide in Michigan.

TERMS RELATED TO MENTAL HEALTH AND YOUNG CHILDREN

- Mental health promotion: Activities offered to individuals and groups to develop competence and self-esteem; focused on supporting general well-being rather than intervening in or preventing illness
- Prevention (sometimes preventive intervention): Interventions that take place before a disorder is diagnosed; three categories of preventive interventions: universal, selective, and indicated
- Early intervention: Services to children ages 0 through 5
- Early childhood mental health: Services that support the social and emotional development of children ages 0 through 5

APPENDIX B: SITE VISIT PROTOCOL

EARLY CHILDHOOD MENTAL HEALTH

General / Existing Context

- Could you provide some history on how early childhood services got started at your site?
- What was already in place to support these services?
- How do your early childhood mental health services fit in with the overall system of care?
- How do you see these services being sustained after the grant?
- What are the demographics of the population you serve? How have these demographics changed? What is the balance between urban children and suburban children served?
- Do you serve more children from "at risk" groups than children who are not from these groups?
- Would you describe your services as prevention services or intervention services?
- For Positive Education Program in Cleveland: You have been offering early childhood services for over 20 years. What have you learned about early childhood services, to whom they should be offered, and how they should be offered? What has changed over these 20 years in the children and families you serve?
- How are you seeing the effects of recent changes in legislation (for example, Temporary Aid to Needy Families) affect the emotional, mental, and behavioral challenges children face?

Description of Program

- How is your program structured?
- What are the services you provide?
- How do families get to you? How do families access your services?
- Describe the staffing structure.
- Do you use a child developmental specialist? If not, does someone play a similar role?
- What other specialists do you draw on in providing early childhood mental health services?
- What are future directions for your program?

Goals of the Program

- What are the goals and objectives of the program?
- How do you translate these goals into services? What led you to design services the way you designed them?
- What are the outcomes that you are looking for when you design and deliver services? Are outcomes directed primarily toward child, family, community, etc.?
- How do you define early childhood mental health?
- Is there a particular philosophy behind your services?

- How do you view the mental health needs of children in relationship to other early childhood needs (i.e., physical, speech/language, etc.)?
- How do you see your program and services fitting into the lives of very young children and their families? Only/primarily in the area of mental health? More broadly?

Assessment and Diagnosis

- How are assessments and diagnoses done?
- What are the challenges in the assessment and diagnosis process?
- How do you handle diagnosing young children?
- How does this work out in relation to funding and reimbursement?
- If a family does not want a diagnosis for their child, what are the options you might pursue?
- What kinds of outreach and/or prevention does the program do?

Family Participation

- How are families involved?
- More specifically, how are families involved in the design, planning, and delivery of services for very young children?
- In what ways does the family organization connect with families of very young children?
- For families—What are the challenges in recruiting and working with parents of very young families?

Cultural Issues

- What is the cultural mix within your program?
- How do you incorporate various strengths and needs particular to specific cultures into your program?
- What are some cultural challenges you face in the design and delivery of services?

Training

- What kind of training do you offer?
- Who does it? How often does it occur?
- What kind of training do you offer in-house around early childhood mental health?
- What do you think the biggest training issues and challenges are?

Evaluation

- Have you done any evaluation of early childhood mental health services?
- What has you evaluation involved?
- What are the special issues in evaluating early childhood mental health?

Collaborative Relationships

- Who are your major collaborators outside of mental health?
- What has your experience been with collaboration and early childhood mental health?
- What does collaboration look like in early childhood mental health? How does the process work (or not work)?
- How is collaboration in early childhood mental health different from collaboration in other children's mental health services?
- If you could describe the ideal services for very young children and their families in this community, what would they look like?
- How have changes in legislation and policy affected the ways in which you work with other child-serving agencies

EARLY CHILDHOOD MENTAL HEALTH SERVICES SHOULD DO THE FOLLOWING:

- Promote the emotional and behavioral well-being of young children, particularly those whose emotional development is compromised by virtue of poverty or other environmental or biological risks;
- Help families of young children address whatever barriers they face to ensure that their children's emotional development is not compromised;
- Expand the competencies of non-familial caregivers and others to promote the emotional well-being of young children and families, particularly those at risk by virtue of environmental or biological factors; and
- Ensure that young children experiencing clearly atypical emotional and behavioral development and their families have access to needed services and supports.

Excerpted from Knitzer, J. (1999). The historical role of mental health services in Head Start and views from the field. *NHSA Dialogue: A Research-to-Practice Journal for the Early Intervention Field, 2*(2), 194–197.

APPENDIX C: PRINCIPLES FOR EARLY CHILDHOOD MENTAL HEALTH: A SYNTHESIS OF THE LITERATURE

Principles for Early Childhood Mental Health: A synthesis of the literature	
Family-centered	Help is most beneficial when it allows families to meet their needs and goals (Dunst, 1993). Services are provided according to the family's strengths, needs, and priorities (Woodruff, Hanson, McGonigel, & Sterzin, 1990). Family members are key members of the early intervention team (Wehman, 1998). Three main approaches to working with families are used in early childhood services: training parents to teach their child; providing information and support to parents to reduce stress and increase skills; and individualized interventions to facilitate development of the family (Simeonsson & Bailey, 1990). For empowerment of families to better care for and cope with a child with special needs, providers should accept the family as a unit, support them to achieve their own goals, and have positive interactions that promote feelings of competence and success (Cornwall & Korteland, 1997). Family outcomes are considered important because they mediate child outcomes (Beckman, Robinson, Rosenberg, & Filer, 1994).
Individualized (culturally competent)	Universal developmental tasks of early childhood are perceived and experienced in culturally specific ways common to each ethnic group (Devore & Schlesinger, 1996). Culturally competent assessment requires that professionals have familiarity with families' cultural practices (Harry & Anderson, 1994). Diagnostic practices should take account of psychosocial stressors, language barriers, discrimination, and value differences (Cervantes & Arroyo, 1994). Early intervention staff need to discuss with parents their beliefs and values about child-rearing to be able to work more effectively together (Booth, 1997). Families' values, beliefs, coping styles, and ways of defining family are recognized and respected; programs reflect respect for the racial, ethnic, cultural, and SES backgounds of families (Woodruff et al., 1990).
Comprehensive	Ecological model directs attention to the contexts of early childhood development (Bronfenbrenner, 1986). Transactional models of child development see the child as a product of dynamic interactions between child, family, and community (Sameroff, 1993). Ecological, transactional, and family systems models have led to the development of treatment approaches that address the complex needs of children and families in their community context (Wehman, 1998). In a follow-up survey of early education programs, Stayton & Karnes (1994) reported that they were becoming more comprehensive. Services include mental health promotion and a range of preventive (universal, selective, and indicated interventions (Mrazek & Haggerty, 1994; Weissbourd, 1996). The Twenty-First Century School Model is an effective comprehensive model of care for young and school-age children (Zigler & Gilman, 1998). An array of preventive and early identification, outpatient, intensive community services, residential, and family support services for young children is needed (Koyanagi, Feres-Merchant, & Schulzinger, 1998).
Community-based	Informal and formal social support tends to have positive effects on families with young children (Patterson & McCubbin, 1983; Dunst, Trivette, & Deal, 1994). The needs of young children are considered in the context of family and community (Wehman, 1998). Community-based developmental and family support services promote normal patterns of family life (Woodruff et al., 1990).

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Principles for Early Childhood Mental Health: A synthesis of the literature

Coordinated/ Transdisciplinary	No one agency or discipline can meet the diverse, complex, and changing needs of young children with special needs and their families; transdisciplinary and transagency approaches are needed (Woodruff et al., 1990). Project Star is an example of a transdisiplinary/transagency program to address the needs of children with HIV/AIDS and their families (Woodruff & Hanson, 1990). Family-centered early intervention requires interdisciplinary collaboration to meet the diverse needs of young children and their families (Wehman, 1998). When children and families are dealing with complex needs and problems, integrated service delivery models are helpful (Lequerica, 1997).
Family participation	Focus is on improving the well-being of children by enhancing the competencies of caregivers and strengthening relationships with caregivers (Knitzer, 1999). Family-professional collaboration and partnership are central (Woodruff et al., 1990). An empowerment approach views families as capable of identifying and meeting their own needs (Dunst, 1993). Families are filling new roles as consultants and advisors in program-level activities (Woodruff et al., 1990). Families are now viewed as essential members of the early intervention team, with roles in planning interventions and providing services (Wehman, 1998). Ten key elements of family-professional partnerships in early intervention are proposed by Cornwall & Korteland (1997). Families can choose their level of involvement in the program (Woodruff et al., 1990). Evaluation data demonstrate positive outcomes of family involvement in early intervention with infants with low birth weight and prematurity (Guralnick, 1991).
Focused on developmental needs	Fraiberg's model of Infant Mental Health focuses on decreasing stress on parents, increasing parents' self-esteem, and helping mothers to develop positive parenting strategies (Weatherston & Tableman, 1989). Early Intervention efforts are guided by belief in the "unusual potential of intervening in the first few years of life" (Guralnick, 1997). Increasing understanding of nerological development in infancy and early childhood points to the importance of supporting healthy, safe environments (Johnson, 1999; Karr-Morse & Wiley, 1997; Perry, 1995). Diagnostic tools need to be formulated specifically for young children and take account of all relevant areas of the child's functioning (Zero to Three, 1994). Effective programs address the medical, health, and developmental needs of the child as well as the family (Woodruff et al., 1990).
Build on strengths/ resilience	Empowerment approaches recognize and build on families capacities to meet their own needs (Dunst, 1993). Studies of brain development provide evidence of the plasticity of the brain in the early years and children's resilience to overcome harmful events (Johnson, 1999). Temperamental traits may protect children who have been exposed to risk factors or they may develop resilience in overcoming adverse effects (Rutter, 1985). Interventions to promote resilience include enhancing self-esteem, improving achievement, promoting social skills, and strengthening families (Rutter, 1985). Early childhood programs promote protective factors by enhancing social support to families (Knitzer, 1996)

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APPENDIX D: EXAMPLES OF PROMISING PRACTICES AND THEIR IMPLEMENTATION AT THE GRANT COMMUNITIES

	Vermont: Children's Upstream Services Project	**Illinois: Community Wraparound Initiative**	**Southeast Kansas: KanFocus and Project Before**	**Maine: The Kmiqhitahasultipon Program, Indian Township**	**Cleveland, Ohio: Positive Education Program**
Family-centered	Support and information are provided to parents and caregivers.	Services are targeted to families when a parent has a diagnosis of serious mental illness and/or substance abuse; wraparound services are developed and provided.	Family-centered approach combines wraparound services with frequent home visiting in a rural area. Services are targeted to families with a caregiver affected by mental illness and/or substance abuse.	The program fosters links between families, mental health providers, and the community.	Families are fully involved in all aspects of service planning and delivery.
Individualized (culturally competent)	Long-term services are provided where needed.	Wraparound services are designed to support each family.	Wraparound team meetings are small, as a response to family preferences. Assessment includes attention to the cultural practices of a family.	Cultural competence is an integral part of the program philosophy. All staff except one are Passamaquody and several speak the Passamaquody language. Emphasis is on individualizing services to meet the needs of each family.	Services are designed to meet the needs of each unique child and family.
Comprehensive	State Team for Children & Families was developed in 1994 to increase state-level collaboration and foster community partnerships. Outreach team helped develop strategic plans for each region; services are universal; they are available for all young children and their families	Service packages are designed to address family needs and include a broad range of supports, such as attention to housing, employment, and so on.	Wraparound services include attention to such basic needs as food and shelter.	Program Staff link families and children with necessary supports in the areas of physical health, housing, transportation, and related to the emotional and spiritual well-being of the family.	PEP provides three separate programs, Early Intervention Centers, Early Start, and Day Care Plus, designed to improve all aspects of functioning of young children. The services are developed from an ecological model.
Community-based	Program builds on existing services in the community.	Program promotes strong links and supports within the community.	Services are delivered in family homes in rural areas..	Community members are drawn in as service providers and supports to families.	Services are located in the communities in which families live.

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	Vermont: Children's Upstream Services Project	**Illinois: Community Wraparound Initiative**	**Southeast Kansas: KanFocus and Project Before**	**Maine: The Kmiqhitahasultipon Program, Indian Township**	**Cleveland, Ohio: Positive Education Program**
Coordinated/ Transdisciplinary	Program focuses on building relationships with other child-serving agencies and interagency collaboration.	Wraparound teams include representatives from different disciplines.	Programs represent collaborations between Mental Health and Head Start and regular professional consultation with staff.	Staff have made links with other child-serving agencies. The parent advocate works closely with teachers and mental health staff. Psychologists provide consultation.	Several disciplines work collaboratively. Assistance is offered to day care providers.
Individualized (culturally competent)	Long-term services are provided where needed.	Wraparound services are designed to support each family.	Wraparound team meetings are small, as a response to family preferences. Assessment includes attention to the cultural practices of the family.	Cultural competence is an integral part of the program philosophy. All staff except one are Passamaquody and several speak the Passamaquody language. Emphasis is on individualizing services to meet the needs of each family.	Services are designed to meet the needs of each unique child and family.
Family participation	Trainings, workshops, and groups are offered to parents; parent aides are hired; family advocacy organization is active in the Family Training Consortium.	Families have a central role in the design and delivery of services. They are family resource developers who are hired as staff to support families who are receiving services.	Parent specialists contribute to wraparound facilitation and to a continuum of resources.	A full-time parent advocate provides supports to families.	More than half the staff are parents who previously received services. There is shared decision making at all levels.
Focused on developmental needs	Program has several parts: Welcome Baby Project; Success by Six; Teen Parent Services; playgroups; consultation to day care providers. Services are designed to promote healthy development of all children and to provide services for children with challenges and their families.	Focus is on promoting healthy development of children identified as being at risk because of parental mental illness or substance abuse.	Focus is on the healthy development of young children whose caregiver is affected by mental illness or substance abuse. "Healthy" children also participate in the summer program as "models."	Services may begin even before the child is born. Children are helped through play, recreational, and interactive activities.	Parents receive support and education for effective parenting strategies. Services are based on a model of health and well-being.

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	Vermont: Children's Upstream Services Project	**Illinois: Community Wraparound Initiative**	**Southeast Kansas: KanFocus and Project Before**	**Maine: The Kmiqhitahasultipon Program, Indian Township**	**Cleveland, Ohio: Positive Education Program**
Build on strengths/ resilience	Community development teams plan and coordinate family activities.	Despite targeting services to families with identified risk factors, the focus is on working with family strengths.	Strength-based assessment is the foundation for developing goals and objectives with each family.	Culture is viewed as a strength.	Parents are given opportunities for experiential learning as they participate in program activities.
Service array	Service array is uniquely configured in each community and includes a variety of universal and targeted preventive and early intervention services.	Service array includes play therapy, respite, tutoring, day camp, and work with families to achieve goals. Services are targeted to prevent the emergence of problems.	Project Before is a home visiting program; Discovery Head Start is a summer program to help children get ready for school. Program uses targeted intervention.	Services include home visits, recreational activities that provide respite for parents, family support, and education.	Early Intervention Centers, Early Start, and Day Care Plus provide an array of services to support and increase competencies of parents and day care staff.
Unique features and promising practices	Program offers comprehensive training, consultation, and technical assistance to agencies and day care providers.	Videotaping is used in assessment and as a teaching tool with parents.	Home visits are a primary mode of service delivery because of rural transportation problems and a preference for staff to meet with families in their natural environment.	Program is specifically designed for the Passamaquoddy community.	All aspects of program activities have a high level of parent involvement.

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APPENDIX E: RESPONDING TO FAMILIES IN EARLY CHILDHOOD MENTAL HEALTH: A COLLABORATIVE PROGRAM MODEL*

Focus of Attention	Program Response	Intervention
Health promotion: empowering families to provide safe and nurturing environments for their children	Develop collaborations with informal support systems and advocacy groups	Work with families to identify and build on sources of informal support; ensure availability of information, day care, and service coordination to support families
Health promotion: affirming the culture and values of families	Develop team capacity to respect and build on cultural strengths and resources	Assess and support family and community strengths and cultural practices on which families rely
Early identification of emotional and behavioral disorders in young children	Develop team capacity for outreach and community education regarding early childhood mental health	Outreach to child-serving systems and providers to identify and support young children and their families who are experiencing challenges
Basic needs of families (financial resources, food, clothing, housing, health services, transportation, job skills, etc.)	Develop transdisciplinary teams' capacity and inter-system capacity to meet basic needs of families	Assess family needs and strengths; develop plan to meet basic needs and access needed services; provide information, contacts, advocacy
Health needs of all family members	Develop teams to coordinate provision of health/medical services for each family; identify and arrange culturally appropriate health services, including bilingual providers or translators	Assess health issues with family; assist family members to secure needed health/medical services; address cultural/language barriers with family
Substance abuse	Advocate to ensure that substance abuse services for family members and children are available	Assess substance abuse issues and refer for appropriate services
Family emotional and social challenges, such as stress, anxiety, fear, shame, depression, family conflict and violence, child-rearing challenges, and social isolation	Develop teams' capacity for family-centered, individualized responses to families' social and emotional needs	Assess emotional issues, strengths, and goals with families; collaborate with families to develop plan for individualized, culturally competent services, including informal supports
Child developmental issues, including language and motor skills, emotional and physical development, self-help, cognitive, and social skills	Develop teams' capacity and resources to assess and respond holistically to children's developmental needs	At regular intervals assess development using multi-disciplinary team; collaborate with family to develop plan to address all developmental domains using formal and informal supports; refer to specialized services where appropriate; implement plan, monitor progress, and make changes in plan
Child emotional/ behavioral challenges, such as anxiety, fear, grief, depression, withdrawal, insecure attachment, attention deficits, impulsivity, hyperactivity	Develop teams and resources to assess and respond to children's emotional and behavioral disorders	Assess child's emotional/ behavioral challenges; collaborate with family to develop individualized, family-centered plan to address needs; implement plan, monitor, and revise plan

*Adapted from the work of Geneva Woodruff

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